

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

ICD-10 Diagnosis:

Asthma (J45.0) Chronic Spontaneous Urticaria (L50.1) Nasal Polyps (J33.9) Other: _____

Xolair Subcutaneous Injection

- Patients will be observed for 2 hours after their first 3 injections and 30 minutes after subsequent injections to ensure there is no anaphylactic or serious injection reaction
- Prefilled syringes must sit out for 15 minutes prior to administration

Dose:

75 mg 150 mg 225 mg 300 mg 450 mg 525 mg 600 mg Other: _____ mg

Frequency (required to be filled in for all orders):

Every 2 weeks Every 4 weeks Other: _____

Duration: 6 months One year Other: _____

Other Orders/Comments: _____

Prescriber printed name: _____

Prescriber full address: _____

Office phone number: _____ **Office fax number:** _____

Prescriber signature

Date

Time

Questions? Call (419)591-3858. Please fax completed form to (419) 592-4004.



XOLAIR (OMALIZUMAB) ORDER FORM

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TRIAL

This document is currently being trialed.