Omalizumab (Xolair)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ J45.50 Severe persistent asthma, uncomplicated ☐ Z91.010 Allergy to peanuts ☐ Z91.011 Allergy to milk products

☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Z91.013 Allergy to seafood ☐ Z91.0120 Allergy to eggs, unspecified

☐ L50.1 Idiopathic urticaria ☐ J33.0 Polyp of nasal cavity ☐ Z91.018 Allergy to other foods

☐ Other:

PRIMARY MEDICATION ORDER

Omalizumab (Xolair), subcutaneous injection

☑ Patients new to therapy are required to stay for 2-hour observation for the first 3 doses

☑ Patient is required to stay for 30-minute observation for all subesquent doses

• Refill for 12 months unless otherwise noted: _____

DOSE	FREQUENCY
☐ 75mg	☐ Every 2 weeks
☐ 150mg	☐ Every 4 weeks
☐ 225mg	
☐ 300mg	
☐ 375mg	
☐ 450mg	
☐ 525mg	
☐ 600mg	

PRE-MEDICATION

Note: pre-meds not typically indicated for Xolair

☐ Other: _____

Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772