

Omalizumab (Xolair)

Provider Order Form rev. 9/07/26



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 subsequent doses

• Refill for 12 months unless otherwise noted: _____

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