vitalcare
of ROANOKE

601 S. Main St., Suite 110, Keller, TX 76248
P / 682.357.4040 • Fax: 682-357-4042
www.vitalcarenorthtexas.com

XOLAIR (OMALIZUMAB)
INJECTION ORDERS

REQUIRED INFORMATION

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Allergic Asthma (ICD-10: ________________)

☐ Chronic Idiopathic Urticaria (ICD-10: ________________)

J Code: J2357

Pt. Weight ___________ kg Allergies:____

XOLAIR ORDERS

Xolair Dose: ☐ 150mg ☐ 250mg ☐ 300mg ☐ 375mg

Frequency: Subcutaneously Every: ☐ 2 weeks or ☐ 4 weeks

History of Allergic Asthma: Positive Skin or RAST Test: ☐ Yes ☐ No
Test Date:______________

Pre-Treatment IgE Serum:____________________IU/ml Test Date:____________

****Date of last Xolair Injection:**______________________________________

Note: Patient must have and EpiPen in the possession on their appointment date.

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	