MPP INFUSION CENTERS
A MULTISPECIALTY PHYSICIAN COMPANY

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

XOLAIR® (OMALIZUMAB) ORDER FORM

(- Required Fields)*

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

XOLAIR ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

Dosing: 375MG 300MG 225MG 150MG

Frequency: SC every 2 weeks SC every 4 weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Severe Asthma
_____ Chronic Idiopathic Urticaria (CIU)
_____ Other_____

____ Requirement: Patient has an unexpired EPI pen at time of injection and is competent in its use.

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ Pretreatment IgE Level 10/ml (for Asthma indication)
_____ Positive Skin or RAST test to a perennial allergen (for Asthma indication)

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: _____ CMP _____ CBC _____ CRP _____ ESRP _____ HFR _____ UA

____ Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Colorado--------
☐ Lakewood

---------Florida---------
☐ Fort Myers Coming Soon
☐ Jacksonville
☐ Kissimmee Coming Soon
☐ Port St. Lucie
☐ Winter Park

----------Texas----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth Coming Soon
☐ Irving
☐ Rockwall
☐ Southlake
☐ Lewisville
☐ Plano
☐ Tyler

REVISION DATE- 11/2019