MPP INFUSION CENTERS
www.mppinfusion.com

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

XOLAIR® (OMALIZUMAB) ORDER FORM

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **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:

_____ Moderate to Severe Asthma

_____ Chronic Idiopathic Urticaria (CIU)

_____ Other_____

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

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

____ Patient Demographics

____ Insurance Card/Information

____ Clinical/Progress Notes supporting DX

____ Current Medication List and H&P

____ Pretreatment IgE Level (IU/ml)(Asthma indication)

____ Positive Skin or RAST test to a perennial allergen (for Asthma indication)

Last Infusion/Injection Date: _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------Colorado--------
☐ Lakewood

---------Florida---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Winter Park

----------Texas----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

REVISION DATE- 06/2020