VIVO infusion

Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.comHave a Question? (855) 478-1528

XOLAIR® (OMALIZUMAB) ORDER FORM

(- Required Fields)*

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

☐ New Referral ☐ Referral Renewal ☐ Medication/Treatment 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 Injection*:
*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

☐ 375 mg ☐ 300 mg ☐ 225 mg ☐ 150 mg

☐ Every 2 weeks ☐ Every 4 weeks

Physician Signature* _____ **Date*(Referral Valid for One Year)** _____

***NPI #** _____

Infusion will be administered per MPP policy and protocols

ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: _____

REQUIRED DOCUMENTATION CHECKLIST:

- ☐ Patient Demographics
- ☐ Insurance Card/Information
- ☐ 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)

STANDING LAB REQUEST (to be drawn by clinic): ☐ CMP ☐ CBC *Frequency _____

Additional comments/notes:

Locations:

--------Colorado-------
- ☐ Lakewood

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

---------Ohio---------
- ☐ Beachwood
- ☐ Middleburg Hts.
- ☐ Painesville
- ☐ Youngstown
- ☐ Westlake
- ☐ Fairlawn

-------Oklahoma-------
- ☐ Tulsa

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

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