INTRAMED Plus
infusion services

XOLAIR®

INFUSION & MEDICAL CENTER

1. ______________________________ ______________ ______________________

Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select primary diagnosis):

Primary Diagnosis:	________Persistent asthma, uncomplicated	ICD-10 Code: J45.__________
	________Persistent asthma with acute exacerbation	ICD-10 Code: J45.__________
	________Persistent asthma with status asthmaticus	ICD-10 Code: J45.__________
	________Chronic Idiopathic Urticaria	ICD-10 Code: L50.1__________
	________Other: ______________________	ICD-10 Code: __________

Allergies:____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes supporting primary diagnosis
- Diagnostic testing documentation (Skin or RAST Test)
- Pre-Treatment IgE results

Patient
Weight: __________ lbs.
Height:__________ in.

XOLAIR® (omalizumab) J Code: J2357

4. Drug Order:

Xolair (omalizumab): ________ mg ______# Refills (Recommended 6-8)

Administer subcutaneously every ❑ 2 weeks or ❑ 4 weeks

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ______________________ / ______________________ Date: __________

Dispense as written Substitution permitted

Printed Physician's Name:______________________________Contact Phone #: ________________

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754**	**INFUSION CENTER LOCATIONS** **COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

APRIL 2020