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 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):** Administer_____ mg subcutaneously every ❑ 2 weeks or ❑ 4 weeks

Doses authorized for ❑ 6 months, ❑ 12 months, or ❑ Other:_____

**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**<br>**CENTRAL FAX 803.999.1754** | **INFUSION CENTER LOCATIONS**<br>**COLUMBIA CHARLESTON GREENVILLE**<br>**CENTRAL INTAKE PHONE 803.999.1760** |

APR 2023