

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 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
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