

# Omalizumab (Xolair)

Provider Order Form rev.

6/17/2026



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Phone: \_\_\_\_\_  
Patient Address: \_\_\_\_\_ Patient Email: \_\_\_\_\_  
Allergies: \_\_\_\_\_  NKDA Weight (lbs/kg): \_\_\_\_\_ Height (in/cm): \_\_\_\_\_  
Sex:  M /  F Date of Last Infusion: \_\_\_\_\_ Next Due Date: \_\_\_\_\_ Preferred Location: \_\_\_\_\_

## DIAGNOSIS (Please provide ICD-10 code in space provided)

Asthma: \_\_\_\_\_ Chronic Rhinosinusitis: \_\_\_\_\_ Chronic spontaneous urticaria: \_\_\_\_\_  
IgE Mediated Food Allergy: \_\_\_\_\_ Other (include description): \_\_\_\_\_

## THERAPY ADMINISTRATION

- Administer Xolair subcutaneously. Divide doses exceeding 150mg among multiple injection sites to limit injections to not more than 150mg per site.
- Following the first three injections, monitor the patient for post-injection observation period of 2 hours. For all subsequent injections, monitor patient for 30 minutes.

## DOSING (Choose one)

For Chronic Spontaneous Urticaria:  150mg /  300mg For  
Asthma/Rhinosinusitis/Food Allergy: \_\_\_\_\_ mg  
(dose based on IgE levels and weight)

## FREQUENCY

Every \_\_\_\_\_ weeks

## ADDITIONAL ORDERS

## LABORATORY ORDERS

Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

Other: \_\_\_\_\_

## NURSING

- Hold infusion and notify provider for reports signs or symptoms of serum sickness (fever, rash, joint pain/swelling/stiffness, muscle pain, swollen lymph nodes)
- Confirm patient has epinephrine auto-injector if required and understands indications for use.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

Preferred Contact Name: \_\_\_\_\_ Preferred Contact Email: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, & number of flares per year  
**Required Labs:** Skin test, IgE

\_\_\_\_\_  
Provider Name (print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

**Disclaimer:** By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.