Omalizumab (Xolair)

Provider Order Form rev.
10/21/2026

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.
☑ 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

Anaphylaxis Prevention: (Recommended)

☐ Patient has an EpiPen to be used for this therapy.
☐ Rx for EpiPen has been sent to retail pharmacy.
☐ Patient does not require EpiPen for this therapy.

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.