Pharmacy SOLUTIONS

XOLAIR REFERRAL FORM

Phone: 877.794.9833 Fax: 855.861.4941
10004 S. 152nd St, Suite C, Omaha NE 68138

Patient Information

Last Name	First Name	DOB
Address		City
State	ZIP	Phone
SSN	Allergies	
Sex	Weight (kg)	Height (ft,in)
Emergency Contact	Phone	
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		City
State	ZIP	Phone
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact		Phone/Pager
Fax		Email

Prescriber Specialty: ☐ Allergist ☐ Pulmonologist ☐ ENT ☐ Primary Care ☐ Pediatrician ☐ Dermatologist ☐ Other:

Diagnosis/Clinical Information FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA OR CIU

ICD-10-CM: ☐ J45.40 Moderate persistent asthma, uncomplicated ☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Idiopathic urticaria ☐ Other:

Concomitant therapies (check all that apply): ☐ Short acting beta agonist ☐ Long acting beta agonist ☐ Systemic glucocorticoids
☐ H1 antihistamines ☐ Decongestants ☐ Immunotherapy ☐ Inhaled corticosteroid ☐ Leukotriene modifers ☐ Nasal steroids
☐ Proton pump inhibitor ☐ H2 antagonist ☐ Other:

Allergic Asthma: ☐ History of positive skin or RAST test to a perennial aeroallergen ☐ Symptoms inadequately controlled with ICS
Pretreatment serum IgE level: _____IU/mL Date obtained: _____/_____/_____
Pretreatment FEV_1 (if available): _____% Date obtained: _____/_____/_____
Chronic Idiopathic Urticaria: ☐ Patient has had CIU for 6 weeks or more

Prescription type: ☐ Naive/New Start ☐ Restart ☐ Continued Treatment ☐ Last Injection Date: _____/_____/_____

Prescription Information

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Xolair - Allergic Asthma Every FOUR weeks dosing. *(dose dependent on weight and IgE levels)*	150mg single use vials Current weight: _____kg Weight date: ____/____/____	☐ Administer 75mg/dose every 4 weeks ☐ Administer 150mg/dose every 4 weeks ☐ Administer 225mg/dose every 4 weeks ☐ Administer 300mg/dose every 4 weeks ☐ Other: Administer _____mg/dose every 4 weeks		
☐ Xolair - Allergic Asthma Every two weeks dosing. *(dose dependent on weight and IgE levels)*	150mg single use vials Current weight: _____kg Weight date: ____/____/____	☐ Administer 225mg/dose every 2 weeks ☐ Administer 300mg/dose every 2 weeks ☐ Administer 375mg/dose every 2 weeks ☐ Other: Administer _____mg/dose every 2 weeks		
☐ Xolair - CIU *(fixed dose, not dependent on weight or IgE)*	150mg single use vials	☐ Administer 150mg/dose every 4 weeks ☐ Administer 300mg/dose every 4 weeks ☐ Other: Administer _____mg/dose every 4 weeks		
☐ EpiPen		Use as directed	2	
☐ EpiPen Jr.		Use as directed	2	

Do you require diluent and supplies? ☐ No ☐ Yes -- 10mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringe as needed for reconstitution, 18-21 gauge needles as needed for reconstitution; 21-27 gauge needles as needed for administration

Date needed: _____/_____/_____ Medication delivery to (choose one): ☐ Prescriber ☐ Home ☐ Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)