Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Xolair Injection ORDER

(omalizumab)

*****_Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications_

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:_____**

Diagnosis:_____

DX CODES: ***ICD-10*** : **_____, _____, _____**

Xolair (*omalizumab*) Subcutaneous Injection Dosage:

□ ____ mg

Frequency: □ **Every 2 wks.** □ **Every 4 weeks**
□ **Other:_____**

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____Office Fax Number: _____