RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Xolair Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Xolair Medication Orders

Dosage

- _____ 300mg subcutaneously once every 2 weeks
- _____ 300mg subcutaneously once every 4 weeks
- _____ 225mg subcutaneously once every 4 weeks
- _____ 375mg subcutaneously once every 4 weeks
- _____ Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Asthma, moderate to severe allergic ____ Nasal polyps ___ Chronic spontaneous urticaria
- _____Other _____
- ICD 10 code _____

Pre-Medication	Refills
• Tylenol _____mg • Benadryl _____ mg __IV or ___PO • Solumedrol IV Push _____ mg • Other _____	• Zero _____ • Treatments for 1 year _____ • Other _____

Required Documentation

○ **Insurance Cards (Front and Back)**	○ **Patient Demographics**	○ **Recent Progress Notes**

Special Instructions/Notes

Is patient required to have epi-pen present at time of appointment? ____ Yes or ____ No

_____ _____

Prescribing Provider Signature **Date of Signature**

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_____ _____

Prescribing Provider Signature **Date of Signature**