Xolair® Referral Form

University Hospitals Home Care Services
4510 Richmond Road
Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Provider Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

_____

Patient Demographics

Name: _____ **DOB:** _____ ☐ **M** ☐ **F**

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Weight: _____ ☐ lb ☐ kg **Height:** _____ ☐ in **Will this be the patient's first dose?** ☐ Yes ☐ No (If no, date of last dose: _____)

Allergies: _____ **Latex allergy?** ☐ Yes ☐ No

For asthma patients: Positive skin or in-vitro reactivity to perennial aeroallergen: ☐ Yes ☐ No **Pre-treatment IgE level:** _____ **Date:** _____

Prior Treatment	Duration	Response

Other notes: _____

_____

Prescription Information

Xolair® Dose	Frequency	Quantity	Refills
Asthma: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg administer subcutaneously* *Maximum dose of 150mg administered per injection site.	☐ Every 2 weeks ☐ Every 4 weeks	28-day supply	_____
Chronic Idiopathic Urticaria: ☐ 150mg ☐ 300mg administer subcutaneously* *Maximum dose of 150mg administered per injection site.	Every 4 weeks	28-day supply	_____

For all patients receiving Xolair® (regardless of indication):

Dispense: EpiPen autoinjector (or equivalent), Quantity: #1 (one) 2-pack, Dose: 0.15mg for weight < 30kg, 0.3mg for weight ≥ 30kg. SIG: Inject intramuscularly in the event of allergic reaction. Patient to bring EpiPen to all appointments and have available at all times following administration of each dose.

Site of Care: Administer at Home Care Ambulatory Infusion Center (not eligible for administration in the home)

Provider Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____