

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: _____ <input type="checkbox"/> M <input type="checkbox"/> F Address: _____ Phone: _____ 2 nd Phone: _____ MRN: _____ Primary Language: _____ Functional Limitations: _____																		
Clinical Information	Diagnosis (Include ICD-10 Code): _____ Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in Will this be the patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last dose: _____) Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No For <u>asthma</u> patients: Positive skin or in-vitro reactivity to perennial aeroallergen: <input type="checkbox"/> Yes <input type="checkbox"/> No Pre-treatment IgE level: _____ Date: _____																		
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">Prior Treatment</th> <th style="width: 33%;">Duration</th> <th style="width: 34%;">Response</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>				Prior Treatment	Duration	Response												
Prior Treatment	Duration	Response																	
	Other notes: _____ _____																		
Prescription Information	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 55%;">Xolair® Dose</th> <th style="width: 15%;">Frequency</th> <th style="width: 15%;">Quantity</th> <th style="width: 15%;">Refills</th> </tr> </thead> <tbody> <tr> <td> Asthma: <input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg administer subcutaneously* *Maximum dose of 150mg administered per injection site. </td> <td> <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks </td> <td>28-day supply</td> <td>_____</td> </tr> <tr> <td> Chronic Idiopathic Urticaria: <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg administer subcutaneously* *Maximum dose of 150mg administered per injection site. </td> <td>Every 4 weeks</td> <td>28-day supply</td> <td>_____</td> </tr> </tbody> </table>				Xolair® Dose	Frequency	Quantity	Refills	Asthma: <input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg administer subcutaneously* *Maximum dose of 150mg administered per injection site.	<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks	28-day supply	_____	Chronic Idiopathic Urticaria: <input type="checkbox"/> 150mg <input type="checkbox"/> 300mg administer subcutaneously* *Maximum dose of 150mg administered per injection site.	Every 4 weeks	28-day supply	_____			
Xolair® Dose	Frequency	Quantity	Refills																
Asthma: <input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg administer subcutaneously* *Maximum dose of 150mg administered per injection site.	<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks	28-day supply	_____																
Chronic Idiopathic Urticaria: <input type="checkbox"/> 150mg <input type="checkbox"/> 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: _____																		

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.