INTRAMED Plus
infusion services

XOLAIR®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select primary diagnosis):

Primary Diagnosis: _____Persistent asthma, uncomplicated ICD-10 Code: J45._____
_____Persistent asthma with acute exacerbation ICD-10 Code: J45._____
_____Persistent asthma with status asthmaticus ICD-10 Code: J45._____
_____Chronic Idiopathic Urticaria ICD-10 Code: L50.1_____
_____Other: _____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes supporting primary diagnosis
- Diagnostic testing documentation (Skin or RAST Test)
- Pre-Treatment IgE results

Patient
Weight: _____ lbs.
Height:_____ in.

XOLAIR® (omalizumab) J Code: J2357

4. Drug Order:

Xolair (omalizumab): Administer_____ mg subcutaneously every ❑ 2 weeks or ❑ 4 weeks

Doses authorized for ❑ 6 months, ❑ 12 months, or ❑ Other:_____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION **CENTRAL FAX 803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**