REVITALIZE
INFUSION CENTER

Xolair®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

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)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies
- Required Information:
  - Diagnostic testing documentation (skin or RAST test)
  - Pre- Treatment IgE levels

Height: _____

Weight: _____

Xolair (omalizumab) Orders:

Administer_____ mg subcutaneously every ☐ 2 weeks or ☐ 4 weeks for 12 months

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus