PARAGON
INFUSION CENTERS

XOLAIR (OMALIZUMAB)
INJECTION ORDERS

PATIENT INFORMATION
☐ *Demographics attached*

Patient Name: ______________________ DOB: __________ Phone: ______________________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

J Code: J2357 Diagnosis: ☐ Allergic Asthma ICD-10 Code: __________

☐ Chronic Idiopathic Urticaria ICD-10 Code: __________

Patient Weight: __________ lbs.

Allergies: ____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

XOLAIR ORDERS

Xolair Dose: ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg

Frequency: Subcutaneously Every: ☐ 2 weeks or ☐ 4 weeks

History for Allergic Asthma: Positive Skin or RAST Test: ☐ Yes ☐ No

Test Date: __________

Pre-Treatment IgE Serum: __________ IU/mL Test Date: __________

** **Date of last Xolair Injection:** ______________________

Note: Patient must have an EpiPen in their possession on their appointment date.

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc.and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ______________________________ Date: __________

Physician Name: ______________________________

Phone: __________ Fax: __________ Contact Person: ______________________

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 Fax: 855-889-2946	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta

PARAGONHEALTHCARE.COM
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