Xolair (omalizumab)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

- ☐ J33.0 Polyp of nasal cavity
- ☐ J45.50 Severe persistent asthma, uncomplicated
- ☐ L50.1 Idiopathic urticaria
- ☐ Z91.010 Allergy to peanuts
- ☑ Z91.011 Allergy to milk products
- ☐ Z91.012 Allergy to eggs
- ☐ Z91.013 Allergy to seafood
- ☐ Z91.018 Allergy to other foods
- ☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- ☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
- ☐ Cetirizine (Zyrtec) 10mgPO
- ☐ Loratadine (Claritin) 10mgPO
- ☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
- ☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Positive RAST or Skin Test
Pre-Treatment Serum IgE
☐ Other: _____

Xolair Administration (Select one):

- ☐ Xolair _____mg SubQ injection every 2 weeks
- ☐ Xolair _____mg SubQ injection every 4 weeks
- ☐ Other: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454