Intravene – Xolair for CIU Injection Orders (rev 10/2015)
Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name ______________________________
Address ______________________________
City ______________________________
State ______________ Zip Code ________
Home Phone # ________________________
Work Phone # ________________________
DOB _________SSN __________________
Height ____________ Weight ________lbs
Drug Allergies________________________
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name ___________________________
Physician Address_________________________
____
Physician Phone(_____)_____________________
Physician Fax(____)________________________
NPI#__________________DEA#_____________
State License#______________________________

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DIAGNOSIS : (ICD-10 required)

☐ ______________________________ ______________________________
☐ ______________________________ ______________________________
☐ ______________________________ ______________________________

□ **Patient has had CIU for 6 weeks or more**

Other CIU therapies
□ **H1 antihistamines**
□ **Other (specify):___________________________________**

PRESCRIPTION INFORMATION:

Prescription Type: □ Naïve patient □ Restart □ Continue treatment- Last injection_____

Prescription Dispense XOLAIR subcutaneously
□ **150mg/dose every 4 weeks**
□ **300 mg/dose every 4 weeks**

Duration: □ 1 year □ 6 months □ 3 months □ other_____________

Signature, prescribing MD _________________________ Date ________________

Anaphylactic meds available at the bedside:
Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD
Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD
Diphenhydramine 50mg vial. Administer 50mg IV push upon order of MD

VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL