Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

XOLAIR (omalizumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis
Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Ceterizine 10mg PO
- ☐ Loratadine 10mg PO
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ Other:

PRIMARY MEDICATION ORDER

Dosage
- ☐ 150 mg
- ☐ 225mg
- ☐ 300mg
- ☐ 375mg

Frequency
- ☐ every 2 weeks
- ☐ every 4 weeks

Patient Weight:
_____ lbs
_____ kg

Allergic Asthma History:
- ☐ Positive RAST or Skin Test Test Date: _____
- ☐ Pre-treatment Serum IgE Test Date: _____

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____