Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Severe Eosinophilic Asthma	ICD 10 Code: J45.50
☐ Chronic Idiopathic Urticaria	ICD 10 Code: L50.1
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis (must be within 1 year)
☐ Pulmonary Function Tests (asthma only)	☐ Perennial aeroallergen test or skin test results (asthma only)
*Patient may be required to submit a pregnancy test prior to treatment	☐ Serum IgE level

List Tried & Failed Therapies, including duration of treatment:

1)
2)
3)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt: (in kg) BMI:

Severe Eosinophilic Asthma Dosing	Please indicate dose in blank space below, in increments of 75mg, based on the pretreatment eosinophil count and body weight. ☐ J2357 Xolair _____ mg SubQ every 2 weeks ☐ J2357 Xolair _____ mg SubQ every 4 weeks
Chronic Idiopathic Urticaria Dosing	☐ J2357 Xolair 150 mg SubQ every 4 weeks ☐ J2357 Xolair 300 mg SubQ every 4 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** _____ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Ph. 217-258-4150
Suite 204 Fax 217-348-2579
Mattoon, IL 61938

☐ EFFINGHAM
901 Medical Park Dr. Ph. 217-342-7500
Suite 201 Fax 217-342-7499
Effingham, IL 62401

MEDICATION ORDERS - XOLAIR (OMALIZUMAB)

Clinics Scan to: Physician Orders