



**Heartland Infusion
Pharmacy**

Phone: (865) 862 - 4557

www.heartlandinfusion.com

Fax: (865) 862 - 4556
Alt. Fax: (865) 867 - 7081

Xolair Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status:	<input type="checkbox"/> New referral	<input type="checkbox"/> Dose or frequency change	<input type="checkbox"/> Order Renewal
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PATIENT INFORMATION

Name: _____	
Home Phone: _____	Cell Phone: _____
Email: _____	Last four Social Security number _____
DOB: _____	Height: _____ Weight: _____
Allergies: _____	
ICD-10 Diagnosis Code: _____	Years with Disease: _____
TB Test (Circle One): Skin Quantiferon Chest Xray	Result: _____ Date: _____

LABORATORY ORDERS		
<input type="checkbox"/> CBC w/ Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other _____
<input type="checkbox"/> Quantiferon TB (annually)	Due: _____	
<input type="checkbox"/> Other		

Therapy Orders
<input type="checkbox"/> Administer <input type="checkbox"/> 75mg <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg Xolair (omalizumab) SQ every
<input type="checkbox"/> 2 weeks <input type="checkbox"/> 4 weeks <input type="checkbox"/> other (specify): _____
<input type="checkbox"/> Nursing per Heartland Nursing Procedures (incl reaction management)

<input type="checkbox"/> Pre-Medications	<input type="checkbox"/> No routine pre-medications required
<input type="checkbox"/> Tylenol (acetaminophen) _____ mg PO	<input type="checkbox"/> Zyrtec (cetirizine) 10 mg PO
<input type="checkbox"/> Solu-Medrol (methylprednisolone) _____ mg IV	<input type="checkbox"/> Claritin (loratadine) 10 mg PO
<input type="checkbox"/> Benadryl (diphenhydramine) _____ mg <input type="checkbox"/> PO <input type="checkbox"/> IV	
<input type="checkbox"/> Other: _____	

PHYSICIAN INFORMATION

Physician's Name: _____		
License #: _____	NPI#: _____	DEA#: _____
Address: _____		
City: _____	State: _____	Zip: _____
Office Contact: _____	Email: _____	
Office Phone: _____	Office Fax: _____	

Physician Signature: _____ Date: _____

Patient is being referred to: Knoxville Morristown Kingsport