Cumberland Vital Care

Fax Referral To: (931) 456-4857

Direct Phone: (931)456-0680

XOLAIR ORDER FORM

Date: ______________________ ICD-10 Code: ______________________

Patient Name: ______________________ Allergies: ______________________

Date of Birth: ______________________ Weight: ________ lbs OR ________ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: ______________________

PROVIDER INFORMATION

Ordering Provider: ______________________ Provider Fax: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Provider Phone: ______________________

MEDICATION ORDER

Xolair

✓ Administer ________ mg of Xolair subcutaneously every ________ weeks.

✓ *TwelveStone staff will encourage patients to remain on-site for a two hour observation following their first three injections of Xolair, followed by a 30 minute observation period for each subsequent injection per policy.*

☐ By checking this box, you indicate that your patient is not subject to an observation period and may exit the facility immediately following injection.

Refills x one year from date of signature unless indicated below.

☐ ________ Refills

Per TwelveStone policy, patient must have an Epipen on hand at each appointment. If patient does not have an Epipen, the following will be ordered unless otherwise indicated:

✓ **Epipen 0.3mg autoinjector to be administered SQ or IM to outer thigh as directed in the event of a life-threatening allergic reaction.**
Dispense: 2 pens
Refills: 2 refills

☐ *Urticaria Diagnosis Only:*
By checking this box, you indicate that your patient does not require an Epipen prescription and does not need an Epipen on hand at each appointment.

PRE-MEDICATIONS

ORAL

- ☐ Acetaminophen: ______325mg ______500mg ______650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ______25mg ______50mg
- ☐ Famotidine: ______20mg ______40mg
- ☐ Ibuprofen: ______200mg ______400mg ______600mg
- ☐ Ondansetron: ______4mg ______8mg
- ☐ Other: ______________________

IV

- ☐ Dexamethasone: ______4mg ______8mg
- ☐ Diphenhydramine: ______25mg ______50mg
- ☐ Famotidine: ______20mg ______40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ______4mg ______8mg
- ☐ Other: ______________________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Ofice Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:

______________________ ______________
Prescriber Name Date

Substitution Allowed:

______________________ ______________
Prescriber Name Date

V 10.31.23

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