LUX INFUSION
HEALTH. TEAM. EXCELLENCE

Xolair Order Form

Select patient referral location: ☐ Anchorage ☐ Palmer ☐ Fairbanks

Please fax or securely email to 1-907-921-7669 or RX@luxinfusion.com.
For new referrals, please **include recent labs and last two office visit notes.**
Clinic Phone Number: 1-907-744-1944 · luxinfusion.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: ☐ M ☐ F	Weight:
Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable):*	

2. PHYSICIAN INFORMATION

Physician's Name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION *(and year of diagnosis)*

☐ Severe Asthma (_____) ☐ Allergic Asthma (_____) ☐ CIU (_____) ☐ **ICD 10** (_____)
☐ Other *(specify):* _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION *(requires new order every 12 months)*

XOLAIR

☐ Administer _____ mg SubQ every _____ weeks, **OR**
☐ Administer _____

☐ Vital signs per LUX Protocol
☐ Anaphylaxis & Hydration Management per LUX Protocol

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Cetirizine (Zyrtec) 10mg PO *(or other non-sedating anti-histamine)*
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV *(requires driver)*
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other: _____

POST-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg PO
☐ Prednisone _____ mg PO
☐ Other: _____

6. SIGNATURE *(required)*

_____ _____
PHYSICIAN'S SIGNATURE DATE

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