



Xolair Prescription Referral

BIOMED Pharmaceuticals

Phone: (817) 923-4495

Toll Free: (866) 923-4495

Intake Fax: (866) 923-4492

Corporate Office 1512 8th Ave. Suite 100 Fort Worth, TX 76104	Desoto 2727 Bolton Boone Dr. Ste 110 Desoto, TX 75115	Houston 1919 N. Loop West, Ste 180 Houston, TX 77008	Tyler 837 S. Fleishel Tyler, TX 75701	San Antonio 211 North San Saba, Suite 205 San Antonio, TX 78207
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Name: _____ Date of Birth: _____
 SS#: _____
 Parent or Guardian: _____ Home Phone: _____ Work Phone: _____
 Address: _____ City: _____ St. _____ Zip _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____ Male ___ Female ___
 Emergency Contact Name _____ Relationship _____

Primary Insurance: _____ Phone #: _____ Subscriber: _____ DOB: _____ ID#: _____ Policy/Group #: _____ Employer: _____	Secondary Insurance: _____ Phone #: _____ Subscriber: _____ DOB: _____ ID#: _____ Policy/Group #: _____ Employer: _____
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Prescription Drug Card: Name _____ Group# _____ ID# _____

Diagnosis:
 ___ 493. ___ Asthma (please enter code specifically) Lab Results: ___ History of positive skin or RAST test to a perennial aeroallergen
 ___ Other: _____ Pretreatment serum IgE level ___ IU/ml Test Date: _____
 Is the Patient Currently on any medications? ___yes ___no Clinical Impressions: _____

List medications and dosage _____ Allergies: _____ Patient Weight: _____

Prescription:
 Dispense Xolair (Omalizumab) For Subcutaneous use, 150-mg vial
 ___ 150 mg/dose subcutaneously every 4 weeks
 ___ 300 mg/dose subcutaneously every 4 weeks
 ___ 225 mg/dose subcutaneously every 2 weeks
 ___ 300 mg/dose subcutaneously every 2 weeks
 ___ 375 mg/dose subcutaneously every 2 weeks
 Dispense:
 ___ Diluent: 10 ml vial preservative-free sterile water for injection
 ___ 3-ml syringes as needed for reconstitution
 ___ 18 ga needles as needed for reconstitution
 ___ 25 ga needles as needed for administration
 ___ Sharps container on an as needed basis
 ___ epipen prn anaphylaxis

Lab:
 ___ Conduct RAST and Total IgE test
 ___ Administer at Alliance Ambulatory Infusion Center-Monitor
 ___ Monitor patient ___ min post injection
 Or
 ___ Dispense for self administration
 Dispense ___1 ___2 ___3 ___6 months supply
 Refill _____ times

Physician Certification: _____ TPI # _____ UPIN# _____ Tax ID# _____ NPI #
 Signature: _____ Date _____
 Print Name: _____ DEA # _____
 Address: _____ City _____ State _____ Zip _____
 Phone: _____ Fax: _____ **Thank you for your referral.**



Please send front and back copies of all insurance cards with referral.