WEST TEXAS
DIGESTIVE DISEASE CENTER

Houssam Al Kharrat
Gastroenterology
5115 80th Street
Lubbock, TX 79424
Phone: (806) 788-4368
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South Plains
Infusion

XOLAIR (Omalizumab) Injection

Name:_____ DOB:_____ M ○ F ○

Phone #1 :_____(H/W/C) Phone #2:_____(H/W/C)

Patient Weight _____ lbs/_____ kg

Allergies:_____

ICD-10 Code: ○J45.50 (severe persistent asthma, uncomplicated) ○L50.8 (Chronic urticaria)
○Other_____

XOLAIR ORDERS

Dose: ○75mg ○150mg ○225 mg ○300mg ○375mg ○Other_____

Frequency: ○every 2 weeks ○every 4 weeks ○Other_____

○ Refills: ○Zero ○for 6 months ○for 12 months ○Other_____

OBSERVATION/EPI PEN (PLEASE SELECT BELOW)

○Patient is required to have Epi Pen with each treatment
○Patient is NOT required to have Epi Pen
○Patient is required to stay for 30 minute observation period
○Other_____

NOTES

ORDERING PROVIDER

Signature X_____ Date_____

Provider _____ Phone _____ Fax_____

Please FAX: ○Medication Order ○Demographics ○Clinicals ○Labs ○X-Rays
○Front and back of insurance card
to 1-806-302-1241