

**LAWRENCE COUNTY**  
**Memorial  Hospital**  
**DEACONESS ILLINOIS PARTNER**

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Severe Eosinophilic Asthma	ICD 10 Code: J45.50	
<input type="checkbox"/> Chronic Idiopathic Urticaria	ICD 10 Code: L50.1	
<input type="checkbox"/> Other: _____	ICD 10 Code: _____	
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number <input type="checkbox"/> Perennial aeroallergen test or skin test results (asthma only) *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> labs and tests supporting primary diagnosis, including blood eosinophil counts <input type="checkbox"/> Pulmonary Function Tests (asthma only) <input type="checkbox"/> Serum IgE level	
List of tried and failed therapies, including duration of treatment:		
1) _____		
2) _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____		
Severe Eosinophilic Asthma	Please indicate dose in blank space below, in increments of 75mg, based on the pretreatment eosinophil count and body weight	
	<input type="checkbox"/> J2357 Xolair _____ mg SubQ every 2 weeks <input type="checkbox"/> J2357 Xolair _____ mg SubQ every 4 weeks	
Chronic Idiopathic Urticaria	<input type="checkbox"/> J2357 Xolair 150mg SubQ every 2 weeks <input type="checkbox"/> J2357 Xolair 300mg SubQ every 4 weeks	
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
PREMEDICATIONS/ LAB ORDERS		
<input type="checkbox"/> Acetaminophen _____ mg PO PRN <input type="checkbox"/> CBC <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Benadryl _____ mg PO or IV <input type="checkbox"/> CMP <input type="checkbox"/> prior to each infusion or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Methylprednisolone _____ slow IV push <input type="checkbox"/> Other: _____ Date: _____ <input type="checkbox"/> Other: _____		
ADDITIONAL ORDERS/INFORMATION		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION CONTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD. CONTACT US WITH QUESTIONS AT 618-943-8515. FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

**INFUSION ORDERS – XOLAIR (OMALIZUMAB)**