BluHaven HEALTH

Xolair Referral Form

Fax: (984) 370-2352
Phone: (984) 370-2350
Email: connect@bluhaven.com

Patient Information

Name: _____ DOB: _____

Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Weight: _____ ☐ lbs ☐ kgs

Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Most Recent Labs | Medication List

Has patient had results of a positive skin test or in vitro reactivity to a perennial aeroallergen? ☐ Yes ☐ No Date of Test: _____

For idiopathic urticaria: Has the patient remained symptomatic despite H1 antihistamine treatment? ☐ Yes ☐ No

Primary Diagnosis

☐ J33.0 Polyp of nasal cavity
☐ J45.50 Severe persistent asthma, uncomplicated
☐ L50.1 Idiopathic urticaria
☐ Z91.010 Allergy to peanuts
☐ Z91.011 Allergy to milk products
☐ Z91.012 Allergy to eggs
☐ Z91.013 Allergy to seafood
☐ Z91.018 Allergy to other foods
☐ Other: _____

Order Information

Lab Orders (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

☑ Per infusion clinic protocol: No recommended standard pre-meds for Xolair
☐ Provider Prescribed: _____

Primary Medication Order

Xolair SubQ Injection

☐ Xolair _____mg SubQ injection every 2 weeks
☐ Xolair _____mg SubQ injection every 4 weeks
☐ Other: _____

First Dose: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted: _____

Adverse Reaction & Anaphylaxis Orders

☑ Administer acute infusion reaction and anaphylaxis medications per BluHaven Healths' protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

_____ _____

Provider Signature *Date*