



NEWPORT INFUSION XOLAIR REFERRAL FORM

1501 Superior Ave Suite 202 | Newport Beach CA
92663 Ph 949-601-6001 | Fax 866-542-8631
NPI# 1184620866
newportinfusion.com

Today's Date _____

Date Needed _____

Patient Name _____ Date of Birth _____ ☐ Male ☐ Female
Address _____ Apt # _____ City _____ State _____ Zip _____
Telephone _____ Cell _____ SSN _____ Email _____
Allergies _____ Comorbidities _____

Current Medications (including OTC, if necessary, please fax a complete list) _____

Primary Insurance _____ ID# _____ Group # _____

Secondary Insurance _____ ID# _____ Group # _____

Insured's Name _____ Employer _____

City _____ State _____ Phone _____ Please attach patient's insurance cards, front and back

Diagnosis ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation
ICD-10 Code: ☐ Other _____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____ Cells/ μ L Date of test: ____/____/____ Number of asthma exacerbations
(requiring use of systemic corticosteroids and/or hospitalization)
in last 12 months: _____

PRESCRIPTION PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS (front and back)			
Medication	Directions	Quantity	Refills
Xolair TM (omalizumab)	Dose: Inject subcutaneously	Frequency:	
	☐ 75mg	☐ Every 2 weeks	☐ 1
	☐ 150mg	☐ Every 4 weeks	☐ 2
	☐ 225mg		☐ 3
	☐ 300mg		☐ 4
	☐ 375mg		☐ # Refills
		☐ 75mg PFS	
		OR	
		☐ 150mg PFS	

Has the patient been started on a samples? ☐ Yes ☐ No

Total number of XOLAIR (omalizumab) doses received since start date: _____ Date of last injection/treatment: _____

Please attach the following: Most Recent Progress Notes & Lab Results (Eosinophil count) & Full Medication List

Thank you!

Prescriber's Name / Practice _____ Office Contact _____

Address _____ Suite# _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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Please fax completed referral form to
Newport Infusion at (949)484-4150