NEWPORT INFUSION

XOLAIR REFERRAL FORM

1501 Superior Ave Suite 202 | Newport Beach CA
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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 ICD-10 Code: ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ Other _____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____Cells/μL 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™ (omalizumab)	**Dose: Inject subcutaneously** ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg **Frequency:** ☐ Every 2 weeks ☐ Every 4 weeks	☐ _____ 75mg PFS **OR** ☐ _____ 150mg PFS	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ _____ # Refills

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**_____

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