PURE
INFUSION SUITES

INFUSION ORDERS XOLAIR

UTAH PROVIDERS Fax form to:
1-801-991-6924

ALL OTHER PROVIDERS Fax form to:
1-801-931-2631

you must enter a 1 before the fax number

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

Allergies

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

XOLAIR DOSING

☐ Administer ____ mg by subcutaneous (SQ) injection every ____ weeks.

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date/Time

Provider Phone | Provider Fax