Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB:_____

STANDARD XOLAIR® PLAN OF TREATMENT

(Re)Certification Period From_____to_____

PATIENT'S NAME _____ Height: _____ Weight: _____

Allergies:_____

Diagnosis: 493._____ SECONDARY DIAGNOSIS: _____

Complete the 4th & 5th digits to indicate the type of asthma

History:

Other Asthma Therapies (check all that apply)

☐ Short-acting Beta-agonist ☐ Inhaled Corticosteroids ☐ Combination Therapy (LABA/ICS)
☐ Long-acting Beta-Agonist ☐ Leukotriene Modifier ☐ Oral Steroids
☐ Other _____

Lab Results

☐ History of positive skin or RAST test to a perennial aeroallergen

Pre-treatment serum IgE level: _____ IU/ml Test Date: _____

1.0 kU/L = 1.0 IU/ml; 2.4 ng/ml = 1.0 IU/ml

Please send documentation regarding treatment history & labs to support the above

Patient must have in-date Epi-Pen to receive Xolair injection

Medical Justification for Prescribing Xolair:

Orders: *Nurse must visually confirm that patient has their Epi-pen with them every visit*

Obtain weight each visit.
Vital signs prior to subcutaneous administration, then again 15 minutes after administration and every 30 minutes during the extended observation of the first 2 doses.
Monitor patient for 2 hours for first 3 injections, subsequent visits for 30 minutes post injection.
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.
If Anaphylaxis/Acute Systemic Reaction- follow MD protocol for treating
Supplies as needed to complete prescribed therapy.

Dose and Frequency: (Select a frequency *and* a dose)

☐ Subcutaneously every 4 weeks **OR** ☐ Subcutaneously every 2 weeks

☐150mg/dose ☐ 300mg/dose ☐ 225mg/dose ☐ 300mg/dose ☐ 375mg/dose

*******Hold dose until cleared by Allergist:*******

1. **If Peak Flow is less than 80% of individual patients best**
2. **If patient is having S/S of asthma or Upper respiratory symptoms**
3. **If patient is on a Beta Blocker**
4. **Pregnancy**
5. **Fever**

Other: Pharmacist to perform clinical drug monitoring.

(no stamped signatures please)

Physician's Signature: _____ _____ Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name:_____

***PLEASE FAX DEMOGRAPHIC & INSURANCE INFORMATION TO* 866-872-8920**