

Phone: 800-809-1265

MRN: _____

DOB: _____

STANDARD XOLAIR® PLAN OF TREATMENT
 (Re)Certification Period from _____ to _____

Patient's Name _____ Height: _____ Weight: _____

Allergies: _____

Diagnosis: Please check one

- | | |
|--|---|
| <input type="checkbox"/> 493.00 Extrinsic Asthma, unspecified | <input type="checkbox"/> 708.1 Chronic Idiopathic Urticaria (CIU) |
| <input type="checkbox"/> 493.01 Extrinsic Asthma with status asthmaticus | <input type="checkbox"/> 708.8 Other Specified Urticaria |
| <input type="checkbox"/> 493.02 Extrinsic Asthma with acute exacerbation | <input type="checkbox"/> Other: _____ |

History:

Other Asthma or CIU therapies (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Short-acting Beta-agonist | <input type="checkbox"/> Inhaled Corticosteroids | <input type="checkbox"/> Combination Therapy (LABA/ICS) |
| <input type="checkbox"/> Long-acting Beta-agonist | <input type="checkbox"/> Leukotriene Modifier | <input type="checkbox"/> Oral Steroids |
| <input type="checkbox"/> H1 Antihistamines | <input type="checkbox"/> Other: _____ | |

Lab Results (for asthma diagnosis only)

- 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:

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 after 1st injection, 1 hour after 2nd injection, 30 minutes after 3rd injection and then for 20 minutes after subsequent injections.

Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.

Supplies as needed to complete prescribed therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Dose & 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
- Special Orders: _____

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