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: Please check one

- ☐ **493.00 Extrinsic Asthma, unspecified**
- ☐ **493.01 Extrinsic Asthma with status asthmaticus**
- ☐ **493.02 Extrinsic Asthma with acute exacerbation**
- ☐ **708.1 Chronic Idiopathic Urticaria (CIU)**
- ☐ **708.8 Other Specified Urticaria**
- ☐ **Other: _____**

History:

Other Asthma or CIU therapies (check all that apply)

- ☐ Short-acting Beta-agonist
- ☐ Inhaled Corticosteroids
- ☐ Combination Therapy (LABA/ICS)
- ☐ Long-acting Beta-agonist
- ☐ Leukotriene Modifier
- ☐ Oral Steroids
- ☐ H1 Antihistamines
- ☐ 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