MRN:_____

DOB:_____

STANDARD Xolair® (omalizumab) PLAN OF TREATMENT FOR ASTHMA

NOTE: Patient ***may be ineligible*** to receive Xolair® (omalizumab) if patient has signs/symptoms of parasitic infection, is currently being treated for a parasitic infection, or is having acute bronchospasm and/or asthma attack.

1. Patient Name:_____ Height (inches):____ Weight (lbs):____

2. Allergies: _____

3. Diagnosis: ☐ J45.40 Moderate or ☐ J45.50 Severe: Persistent asthma, uncomplicated

☐ J45.41 Moderate or ☐ J45.51 Severe: Persistent asthma with (acute) exacerbation

☐ J45.42 Moderate or ☐ J45.52 Severe: Persistent asthma with status asthmaticus

☐ Other ICD-10 Code/description: _____

4. Dose/Frequency:

Xolair® (omalizumab) subcutaneously every 2 weeks: ☐ 225 mg/dose ☐ 300 mg/dose☐ 375 mg/dose

Xolair® (omalizumab) subcutaneously every 4 weeks: ☐ 75 mg/dose ☐ 150 mg/dose ☐ 225mg/dose ☐ 300mg/dose

Special Orders: _____

(*Administer as subcutaneous injection to upper arm, thigh, or abdomen. No more than 150 mg per injection site)*

Extended post treatment monitoring for any patient new to therapy: monitor patient for two (2) hours after first injection, for one (1) hour after second injection, for 30-minutes after third injection, and then all patients for 15-minutes after each injection thereafter.

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing Xolair® (omalizumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any documented use of inhaled or oral corticosteroids, leukotriene modifiers, short or long acting beta-agonists. Any lab results, Pulmonary Function Tests (FEV_1 and Peak Flow), and/or positive skin test or RAST testing to support diagnosis.** Xolair® is an anti-IgE antibody indicated for **moderate to severe persistent asthma** in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids. Xolair dose of 75 to 375 mg SC every 2 or 4 weeks. Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL), measured before the start of treatment, and body weight (kg). See Product Information for recommended dosing.

☐ If patient is switching biologic therapies, then MD must specify wash-out period prior to starting Xolair® as specified of_____weeks. Last known therapy:_____& last known date received:_____.

☐ Other as requested: _____

Pre-Screening:

☐ Pre-treatment serum IgE level as required for dosing for Asthma. Dosage is determined by initial IgE level and body weight. Do NOT use levels for subsequent dose determinations unless treatment has been interrupted for more than 1 year.

** **Warnings/Precautions:** **Anaphylaxis reactions:** such as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue, has been reported to occur after administration of Xolair®. Anaphylaxis has occurred as early as after the first dose of Xolair®, but also has occurred beyond 1 year after beginning regularly administered treatment. Fever, Arthralgia, and Rash: Stop Xolair® if patients develop signs and symptoms similar to serum sickness. **Acute Asthma Symptoms:** Do not use for the treatment of acute bronchospasm or status asthmaticus. **Malignancy:** have been observed in clinical studies. **Corticosteroid Reduction:** Do not abruptly discontinue corticosteroids upon initiation of therapy. **Eosinophilic Conditions:** Be alert to eosinophilia, vasculitic rash, worsening pulmonary symptoms, cardiac complications, and/or neuropathy, especially upon reduction of oral corticosteroids. **Helminth Infections:** Treat patients with pre-existing parasitic infections before therapy. If patients become infected while receiving treatment and do not respond to anti-helminth treatment, then discontinue Xolair® until parasitic infection resolves. **Pregnancy/Breastfeeding:** Discuss Pregnancy or breastfeeding plans/risks prior to start of therapy. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.