

MRN: _____

DOB: _____

STANDARD Xolair® (omalizumab) PLAN OF TREATMENT FOR URTICARIA

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: L50.1 Chronic Idiopathic Urticaria (CIU) L50.8 Other Specified Urticaria

Other ICD-10 Code/description: _____

4. Dose/Frequency:

Xolair® (omalizumab) subcutaneously every 4 weeks: 150 mg/dose 300 mg/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 (FEV₁ and Peak Flow), and/or positive skin test or RAST testing to support diagnosis.

_____ Xolair® is an anti-IgE antibody indicated for **chronic idiopathic urticaria** in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment. Xolair dose of 150 or 300 mg SC every 4 weeks. Dosing in CIU is not dependent on serum IgE level or body weight.

_____ 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: _____

**** 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.