

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

Xolair® (omalizumab) Standard Plan of Treatment for Asthma

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: <input type="checkbox"/> See list <input type="checkbox"/> NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/> J45.40 - Moderate Persistent asthma, uncomplicated	<input type="checkbox"/> J45.50 - Severe Persistent asthma, uncomplicated
<input type="checkbox"/> J45.41 - Moderate Persistent asthma with (acute) exacerbation	<input type="checkbox"/> J45.51 - Severe Persistent asthma with (acute) exacerbation
<input type="checkbox"/> J45.42 - Moderate Persistent asthma with status asthmaticus	<input type="checkbox"/> J45.52 - Severe Persistent asthma with status asthmaticus
<input type="checkbox"/> - Other:	

REQUESTED DOCUMENTATION:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Pre-treatment serum IgE level as required for dosing	THERAPY:	
			<input type="checkbox"/> Continue current order until insurance approved

Provider Attestation for HCP administration:

<input type="checkbox"/> Provider attests that the patient or caregiver is not competent or is physically unable to administer the Xolair labeled self-administration.	<input type="checkbox"/> The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.
<input type="checkbox"/> Patient has experienced severe hypersensitivity reactions to Xolair or other agents, such as foods, drugs, biologics, within the past 6 months or requires administration and direct monitoring by a healthcare professional.	<input type="checkbox"/> Patient has a history of uncontrolled disease and ordering physician attests that in their clinical opinion, it is not advisable to try the self-administration formulation of requested drug
<input type="checkbox"/> Patient has not received at least 3 doses of Xolair under the guidance of a healthcare provider with no hypersensitivity reactions*	<input type="checkbox"/> Due to patient's weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug.

*Specific reactions: _____

MEDICATION ORDERS:

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.

MEDICATION/FREQUENCY:

Xolair® (omalizumab) subcutaneously every 2 weeks: Xolair® (omalizumab) subcutaneously every 4 weeks:

DOSE:

75mg/dose 150 mg/dose 225mg/dose 300mg/dose 375mg/dose

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

SPECIAL ORDERS:

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 15-minutes after all subsequent injections.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)

DATE

Dispense as written/Brand medically necessary	Substitution permitted
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