Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Xolair® (omalizumab) Standard Plan of Treatment for Nasal Polyps

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:	☐ See list ☐ NDKA

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

☐ J33.0 Polyp of nasal cavity	☐ J33.1 Polypoid sinus degeneration
☐ J33.8 Other polyp of sinus	☐ J33.9 Nasal polyp
☐ _____ - Other:	

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Pre-treatment serum IgE level as required for pretratment dosing

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

Provider Attestation for HCP administration:

☐ Provider attests that the patient or caregiver is not competent or is physically unable to administer the Xolair labeled self-administration.

☐ 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.

☐ Patient has not received at least 3 doses of Xolair under the guidance of a healthcare provider with no hypersensitivity reactions*

☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.

☐ 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

☐ 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 ☐ 450mg/dose

☐ 525mg/dose ☐ 600mg/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-mintues for all subsequent injections.

☑ Refills x 12 months unless noted otherwise here:

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	