

|  |                                       |
|--|---------------------------------------|
| 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 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:  |
|                   | <input type="checkbox"/> See list <input type="checkbox"/> NKDA |

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

|  |  |
|--|--|
| <input type="checkbox"/> J33.0 - Polyp of nasal cavity | <input type="checkbox"/> J33.1 - Polypoid sinus degeneration |
| <input type="checkbox"/> J33.8 - Other polyp of sinus  | <input type="checkbox"/> J33.9 - Nasal polyp, unspecified    |
| <input type="checkbox"/> _____ - Other:                |  |

### REQUESTED DOCUMENTATION:

|   |                  |  |
|---|------------------|--|
| 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    | <b>IF ORDER CHANGE:</b>                                |
| 5 Pre-treatment serum IgE level as required for pretreatment dosing | THERAPY:         |  |
|   |                  | <b>Continue current order until insurance approved</b> |

### 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   
  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 3 injections, and for 30-minutes after all subsequent injections.

Refills x 12 months unless noted otherwise here:

### CARE ORDERS:

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

### 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 |