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 Urticaria

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 ☐ NKDA

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

☐	L50.0 - Allergic Urticaria	☐	L50.1 - Chronic Idiopathic Urticaria (CIU)
☐	L50.8 - Other Specified Urticaria	☐	_____ - 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 REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Pre-treatment serum IgE level as required for pre treatment dosing		☐ **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 4 weeks: ☐ Other:_____

DOSE:

☐ 150 mg/dose ☐ 300mg/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:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated	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	