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 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: ☐ See list ☐ NKDA	

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

☐	J45.40 - Moderate Persistent asthma, uncomplicated	☐	J45.50 - Severe Persistent asthma, uncomplicated
☐	J45.41 - Moderate Persistent asthma with (acute) exacerbation	☐	J45.51 - Severe Persistent asthma with (acute) exacerbation
☐	J45.42 - Moderate Persistent asthma with status asthmaticus	☐	J45.52 - Severe Persistent asthma with status asthmaticus
☐	_____ - 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 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.	☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.
☐ 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 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
☐ Patient has not received at least 3 doses of Xolair under the guidance of a healthcare provider with no hypersensitivity reactions*	☐ 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.

SPECIAL ORDERS:

☐ _____

POST WAIT: *Extended post treatment monitoring for any patient new to therapy*

Standard Palmetto Infusion Post wait per package insert: Monitor patient for two (2) hours after first injection, for (1) hour after second injection, for 30 minutes after third injection, then monitor for 15-minutes with all subsequent injections. Unless otherwise selected below.

☐ **Monitor patient for two (2) hours after first 3 injections, and for 30-minutes after all subsequent injections.**

☐ **Provider specific post wait:** _____

☑ 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	