Palmetto INFUSION®

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

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

Rev. 4.30.25

# Xolair® (omalizumab) Standard Plan of Treatment for Asthma

## PATIENT DEMOGRAPHICS:

Patient Name:

Patient's Phone: | 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:

| | |
|---|---|
| 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 dosing |

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:

PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

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

**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:

✔ 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.

## 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 | |