



Omalizumab (Xolair)

Provider Order Form rev. 10/13/2022

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ☐ J45.50 (severe persistent asthma, uncomplicated) ☐ L50.8 (Chronic urticaria) ☐ Other

If Other, give ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

- ☒ Serum IgE level and date resulted (results) _____
- ☒ Provide nursing care per Nursing Procedures, including reaction management and post-procedure observation

THERAPY ADMINISTRATION

- ☒ Omalizumab (Xolair)
- Dose: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg
 - Route: subcutaneous injection
 - Frequency: ☐ every 2 weeks ☐ every 4 weeks /
 - ☐ other: _____
- ☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

OBSERVATION/EPI PEN (PLEASE SELECT BELOW)

- ☐ Patient is required to have Epi Pen with each treatment
- ☐ Patient is NOT required to have Epi Pen
- ☐ Patient is required to stay for 30 minutes observation period
- ☐ Other: _____

Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL) measured before the start of treatment, and by body weight (kg).

Because of the risk of anaphylaxis, observe patients closely for an appropriate period of time after XOLAIR administration.

Provider Name (Print)

Provider Signature

Date

Please include the following information when submitting a referral for Xolair:

* Patient's current weight and height

* IgE Lab results

* FEV1 test results showing demonstrated airflow limitation: FEV1 less than 80%

* Clinicals to support one or more of the following:

- * Patient has moderate to severe persistent asthma, is 6 years of age or older, has had a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids
- * Patient has chronic idiopathic urticaria, is 12 years of age or older and remains symptomatic despite H1 antihistamine treatment
- * Nasal polyps in adult patients 18 years of age and older with inadequate response to nasal corticosteroids, as add-on maintenance treatment