Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

XOLAIR MEDICATION ORDER

Patient's Name (Last, First, Middle) ________________________________ DOB ______________________

Patient's height in feet and inches ____________________ *Patient's weight in pounds* ________________________

■ Diagnosis

□ J45.40 Moderate persistent asthma, uncomplicated
□ J45.41 Moderate persistent asthma with acute exacerbation
□ J45.42 Moderate persistent asthma with status asthmaticus
□ J45.50 Severe persistent asthma, uncomplicated
□ J45.51 Severe persistent asthma with acute exacerbation
□ J45.52 Severe persistent asthma with status asthmaticus
□ L50.1 Idiopathic urticaria

Allergy Notice: *Xolair prefilled syringe caps may contain latex. If patient has allergy to latex, order Xolair for reconstitution without latex.*

■ Details Needed for Approval for Asthma

- Is the patient's asthma reversible? Please provide details, such as documented PEF response to short-acting inhaled beta-1 agonist.
- Recent laboratory results of the patient's baseline serum IgE levels.
- Documented evidence of specific allergic sensitivity (ie. positive skin test, RAST, etc.)
- Is the patient symptomatic (or inadequately controlled) after at least 3 months of prior combination therapy, including inhaled corticosteroids plus another controller medication)? _____
- Is the patient currently a smoker? _____
- Will Xolair be used concurrently in combination with Fasenra, Nucala or Cinqair? _____

■ Details Needed for Approval for Urticaria

- Is the patient refractory or symptomatic to at least 2 weeks trial of a second-generation H1-antihistamine and/or refractory or symptomatic to at least 1 month trial of updosing/dose advancement (up to 4-fold) of a second generation H1-antihistamine or add-on therapy with a leukotriene antagonist, another H1-antihistamine, a H2-antagonist, or cyclosporin A? _____
- Please provide documentation of baseline evaluation of quality-of-life tools including UAS7, DLQI, CU-Q2oL, AAS or AE-QoL score.
- Will Xolair be used concurrently in combination with Fasenra, Nucala or Cinqair? _____

■ Medication Order

☐ _____mg Xolair (omalizumab) injected subcutaneously every _____ weeks for _____ months.

Dosage may be dependent on serum IgE levels. In such cases prescriber must monitor levels and issue a new order if a change is needed.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: ______________________________ Name: ____________________ Date: ____________________

Address: ____

Phone: __________________ Fax: __________________ Indiv. NPI #: ______________ License: __________________

Best Contact Person in Office: ____________________________ Direct Phone to Contact Person: ________________________

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.