FLOMED INFUSION

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XOLAIR (omalizumab)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____
Required Labs: _____

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient being concurrently treated with any other biologic: _____
- History of Allergic Asthma: Positive Skin or RAST test: ☐ Yes ☐ No Test Date: _____
- Pre-Treatment IgE Serum: _____ IU/mL Test Date: _____
- Date of last Xolair injection: _____

XOLAIR (omalizumab) ORDERS

Dose:
☐ 150mg
☐ 225mg
☐ 300mg
☐ 375mg

Frequency:
Every ☐ 2 weeks ☐ 4 weeks

Note:
Patient must have an EpiPen in their possession on their appointment date.

Additional Orders/Comments: _____

_____

_____

_____

ADULT RESCUE MANAGEMENT PROTOCOL

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

- Following 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.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____