McLeod Health

Place Sticker Here

Omalizumab (Xolair) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

☐ J45.50 Severe persistent asthma, unspecified

☐ J45.51 Severe persistent asthma with (acute) exacerbation

☐ J45.52 Severe persistent asthma with status asthmaticus

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

• Omalizumab (Xolair) (J2357) via subcutaneous injection

● Dose: ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg

● Frequency: ☐ Every 2 weeks

☐ Every 4 weeks

☐ Other: _____

• Order Duration: Six months unless otherwise specified (Other: _____)

Standing Orders:

• Monitor patient for 2 hours following first 3 injections and 30 minutes after subsequent injections

● Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion/injection will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Provide pre-treatment serum IgE level to confirm dosing

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received omalizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)