Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

XOLAIR MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ 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 Authorization for persistent allergic 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 Authorization for chronic idiopathic urticaria:

- Is the patient refractory or symptomatic to at least 1 month trial of a second-generation H1-antihistamine AND 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 instruments including UAS7, DLQI, CU-Q2oL, AAS or AE-QoL score.
- Will Xolair be used concurrently in combination with Fasenra, Nucala or Cinqair? _____

■ Xolair (Omalizumab) Subcutaneous Injection Order

Height in ft/in: _____ Weight in lbs: _____

☐ _____mg 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.

■ Ordering Provider Authorization

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

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

STANDARD 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.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.