

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies: \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

**Financial authorizations require clinical documentation of medical necessity. To ensure compliance, the criteria below must be indicated as completed by office representative. Incomplete documentation will be returned to the referring office for completion, resulting in delays to the patient receiving treatment.**

- Ordering provider is credentialed at Sinai Hospital (Alvin and Lois Lapidus Cancer Center) or Carroll Hospital (William E. Kahlert Regional Cancer Center) to admit and write orders.
- Demographics / insurance information attached, or available in Cerner.
- Provider note dated within 30 days indicating medical need attached, or date if available in Cerner: \_\_\_\_\_
- Pretreatment serum IgE obtained within 90 days, and results attached, or date if available in Cerner: \_\_\_\_\_

**Treatment:**

**Chronic spontaneous urticaria**

Omaliuzumab (Xolair®)     150 mg    **OR**     300 mg    subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): \_\_\_\_\_

**Asthma, moderate to severe allergic**

		Weight (kg)			
		30 to 60	>60 to 70	>70 to 90	>90 to 150
Pretreatment serum IgE (units/mL)	≥ 30 to 100	150 mg every 4 weeks			300 mg every 4 weeks
	>100 to 200	300 mg every 4 weeks			225 mg every 2 weeks
	>200 to 300	300 mg every 4 weeks	225 mg every 2 weeks		300 mg every 2 weeks
	>300 to 400	225 mg every 2 weeks		300 mg every 2 weeks	Use not recommended
	>400 to 500	300 mg every 2 weeks		375 mg every 2 weeks	Use not recommended
	>500 to 600	300 mg every 2 weeks	375 mg every 2 weeks	Use not recommended	
	>600 to 700	375 mg every 2 weeks	Use not recommended		

Omaliuzumab (Xolair®)    \_\_\_\_\_ mg subcutaneously every \_\_\_\_\_ weeks

Duration of therapy (1 year unless otherwise specified): \_\_\_\_\_

**Protocol Orders:**

- Hypersensitivity/Anaphylaxis Medications: Follow Adult Hypersensitivity Nursing Protocol PRN for the treatment of allergic/hypersensitivity reaction.

Physician's Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

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