

Patient Name: _____ DOB: _____

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

Diagnosis: _____ Diagnosis Code: _____

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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:

	Weight (kg)								
	20 to 25	>25 to 30	>30 to 40	>40 to 50	>50 to 60	>60 to 70	>70 to 90	>90 to 125	> 125 to 150
Pretreatment serum IgE (units/mL)	75 mg every 4 weeks			150 mg every 4 weeks			300 mg every 4 weeks		
>30 to 100	75 mg every 4 weeks			150 mg every 4 weeks			300 mg every 4 weeks		
>100 to 200	150 mg every 4 weeks			300 mg every 4 weeks			225 mg every 2 weeks	300 mg every 2 weeks	
>200 to 300	150 mg every 4 weeks		225 mg every 4 weeks	300 mg every 4 weeks		225 mg every 2 weeks		300 mg every 2 weeks	375 mg every 2 weeks
>300 to 400	225 mg every 4 weeks		300 mg every 4 weeks	225 mg every 2 weeks			300 mg every 2 weeks	Do not use	
>400 to 500	225 mg every 4 weeks	300 mg every 4 weeks	225 mg every 2 weeks		300 mg every 2 weeks		375 mg every 2 weeks	Do not use	
>500 to 600	300 mg every 4 weeks		225 mg every 2 weeks	300 mg every 2 weeks		375 mg every 2 weeks	Do not use		
>600 to 700	300 mg every 4 weeks	225 mg every 2 weeks		300 mg every 2 weeks	375 mg every 2 weeks	Do not use			
>700 to 900	225 mg every 2 weeks		300 mg every 2 weeks	375 mg every 2 weeks	Do not use				
>900 to 1100	225 mg every 2 weeks	300 mg every 2 weeks	375 mg every 2 weeks	Do not use					

- Omalizumab (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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