XOLAIR (OMALIZUMAB)
Infusion Orders

PHONE 515.225.2930 | **FAX** 515.559.2495

Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

Patient Name: _____ **DOB:** _____ **Phone:** _____

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:** _____

Medical Information

Diagnosis: ☐ Moderate to severe persistent asthma ☐ Polyp of the nasal cavity ☐ Allergic urticaria

☐ Idiopathic urticaria ☐ Chronic obstructive pulmonary disease **ICD-10 Code:** _____

Patient Weight: _____ lbs. (required) **Allergies:** _____

Therapy Order

Xolair dose:

☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg ☐ 525 mg ☐ 600 mg

Frequency: Subcutaneously every: ☐ 2 weeks x1 year OR ☐ 4 weeks x1 year

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

Other Orders: _____

Lab Orders: _____ **Lab Frequency:** _____

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Provider

Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: _____ **Signature:** _____ **Date:** _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____ **Contact Person:** _____

☐ Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): _____

Service Areas

☐ Des Moines, IA ☐ West Des Moines, IA ☐ Chicago, IL ☐ Omaha, NE ☐ Buffalo, NY ☐ Dallas, TX

☐ Phoenix, AZ ☐ Other _____

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COMPREHENSIVE SUPPORT FOR XOLAIR (OMALIZUMAB) THERAPY

Patient Information

Patient Name: _____ **DOB:** _____

Required Documentation for Referral Processing & Insurance Approval

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's current medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

- ☐ Please indicate any tried and failed therapies (if applicable):
  - ☐ Corticosteroids _____
  - ☐ Long-acting beta 2 agonist _____
  - ☐ Long-acting muscarinic antagonist _____
  - ☐ Antihistamines: _____
  - ☐ Other: _____
- ☐ *Asthma* – Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? ☐ Yes ☐ No
- ☐ *Asthma* – Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? ☐ Yes ☐ No
- ☐ *Nasal polyps* – Does the patient have significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea or loss of smell? ☐ Yes ☐ No

☐ Include labs and/or test results to support diagnosis

- ☐ *Asthma and Polyps* – Does patient have a baseline IgE level of ≥30 IU/mcL ☐ Yes ☐ No **(required – attach results)**
- ☐ Does the patient have an allergy to a perennial aeroallergen? ☐ Yes ☐ No **(required for asthma patients – attach results)**
- ☐ Pulmonary function tests or FEV1 score (if applicable): _____

☐ Is the patient or caregiver not competent or physically unable to administer Xolair for self-administration or patient is not home candidate? **(UHC only)** ☐ Yes ☐ No

☐ **Other Medical Necessity:** _____

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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