

Patient Information				Prescriber Information			
Last Name		First Name		DOB		Practice/Facility Name	
Address				City		Address	
State	ZIP	Phone		State	ZIP	Phone	
SSN		Allergies		Prescriber Name			
Sex		Weight (kg)		Height (ft,in)		Prescriber NPI	
Emergency Contact			Phone			Nurse/Key Contact	
Insurance Plan		Plan ID #		Fax		Email	

Prescriber Specialty: Allergist Pulmonologist ENT Primary Care Pediatrician Dermatologist Other:

**Diagnosis/Clinical Information** FOR APPROPRIATE PATIENTS WITH ALLERGIC ASTHMA OR CIU

ICD-10-CM: J45.40 Moderate persistent asthma, uncomplicated J45.50 Severe persistent asthma, uncomplicated  
L50.1 Idiopathic urticaria Other:

Concomitant therapies (check all that apply): Short acting beta agonist Long acting beta agonist Systemic glucocorticoids  
H1 antihistamines Decongestants Immunotherapy Inhaled corticosteroid Leukotriene modifiers Nasal steroids  
Proton pump inhibitor H2 antagonist Other:

Allergic Asthma: History of positive skin or RAST test to a perennial aeroallergen Symptoms inadequately controlled with ICS  
Pretreatment serum IgE level: \_\_\_\_\_ IU/mL Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Pretreatment FEV1 (if available): \_\_\_\_\_% Date obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_

Chronic Idiopathic Urticaria: Patient has had CIU for 6 weeks or more

Prescription type: Naive/New Start Restart Continued Treatment Last Injection Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Prescription Information**

MEDICATION	STRENGTH	DIRECTIONS	QTY	REFILLS
Xolair - Allergic Asthma Every FOUR weeks dosing. (dose dependent on weight and IgE levels)	150mg single use vials Current weight: _____ kg Weight date: ____/____/____	Administer 75mg/dose every 4 weeks Administer 150mg/dose every 4 weeks Administer 225mg/dose every 4 weeks Administer 300mg/dose every 4 weeks Other: Administer _____mg/dose every 4 weeks		
Xolair - Allergic Asthma Every two weeks dosing. (dose dependent on weight and IgE levels)	150mg single use vials Current weight: _____ kg Weight date: ____/____/____	Administer 225mg/dose every 2 weeks Administer 300mg/dose every 2 weeks Administer 375mg/dose every 2 weeks Other: Administer _____mg/dose every 2 weeks		
Xolair - CIU (fixed dose, not dependent on weight or IgE)	150mg single use vials	Administer 150mg/dose every 4 weeks Administer 300mg/dose every 4 weeks Other: Administer _____mg/dose every 4 weeks		
EpiPen		Use as directed	2	
EpiPen Jr.		Use as directed	2	

Do you require diluent and supplies? No Yes -- 10mL vial preservative-free sterile water for injection, USP; ancillary supplies: 3-mL syringe as needed for reconstitution, 18-21 gauge needles as needed for reconstitution; 21-27 gauge needles as needed for administration

Date needed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Medication delivery to (choose one): Prescriber Home Other:

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: \_\_\_\_\_

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date)

DISPENSE AS WRITTEN/Do Not Substitute (date)

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