

**Xolair Referral Form**
**PATIENT INFORMATION**
**PROVIDER INFORMATION**

 Name \_\_\_\_\_ DOB \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_  
 Email \_\_\_\_\_ Gender  M  F

 Name \_\_\_\_\_ NPI \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Office Contact \_\_\_\_\_ Phone \_\_\_\_\_

**\*REQUIRED\***  Insurance Card Front/Back  Prescription Insurance Card Front/Back  Clinical Notes  Lab/Test Results

**CLINICAL INFORMATION**

 ICD-10 \_\_\_\_\_ Diagnosis Description \_\_\_\_\_  
 Drug Allergies \_\_\_\_\_ Latex Allergy  Yes  No  
 Height \_\_\_\_\_ (in) Weight \_\_\_\_\_ (lbs) Baseline Serum Total IgE: \_\_\_\_\_ FEV1: \_\_\_\_\_  
 Line Access  PIV  Port  PICC  Midline Initial Infusion  Yes  No (If no, date of last infusion \_\_\_\_\_)

**TRIED AND/OR FAILED MEDICATIONS**
**LENGTH OF THERAPY**
**REASON FOR DISCONTINUATION**

 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**MEDICATION**
**DOSE/STRENGTH**
**DIRECTIONS**
**QTY**
**REFILLS**

<input type="checkbox"/> Xolair (Omalizumab)	<input type="checkbox"/> 75mg Syringe <input type="checkbox"/> 150mg Syringe	Inject _____mg SQ every 2 weeks  Inject _____mg SQ every 4 weeks		
<input type="checkbox"/> Other				

**PRE-MEDICATION**
**DOSE/STRENGTH**
**DIRECTIONS**

<input type="checkbox"/> Acetaminophen	500mg	Take 1-2 tablets PO prior to infusion or post-infusion as directed
<input type="checkbox"/> Cetirizine	10mg	Take 1 tablet PO prior to infusion or as directed
<input type="checkbox"/> Diphenhydramine	<input type="checkbox"/> 25mg IV/PO <input type="checkbox"/> 50mg IV/PO	Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Methylprednisolone	<input type="checkbox"/> 40mg <input type="checkbox"/> 125mg	Inject contents of 1 vial IV prior to infusion or as directed
<input type="checkbox"/> Ondansetron ODT	4mg	Take 1-2 tablets prior to infusion or as directed
<input type="checkbox"/> Other:		

 Adverse Reactions Management Protocol (includes hypersensitivity and allergic/ anaphylactic reaction)

**SPECIAL INSTRUCTIONS:**

My signature below certifies that (1) The above-named individual is my patient and the therapy identified has been deemed medically necessary. (2) All information provided is true and accurate to the best of my knowledge. (3) I authorize the use of BrookWell Health's Infusion and line access and flushing protocols. (4) I authorize BrookWell Health to substitute the approved biosimilar if required / authorized by insurance. (5) I authorize BrookWell Health to perform any necessary emergency and/or anaphylaxis treatment as per BWH protocol (\*see reverse).

Provider Name \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

## Adverse Reaction Management Protocol

### Hypersensitivity reaction including, but not limited to, fever, rash, itching, rigors, sneezing, nausea and vomiting

If reaction occurs:

- If indicated, stop infusion
- Maintain / establish vascular access
- May utilize the following PRN medications as follows:
  - \* Allergies, hives, itching - Diphenhydramine 25-50mg PO/IV as a single dose, may repeat with either medication if needed
  - \* Nausea, vomiting, heartburn - Ondansetron 4mg ODT (may repeat in 20 minutes if nausea continues) or Famotidine 20mg PO as a single dose; if severe - give Ondansetron 4mg slow IVP (may repeat in 20 minutes if nausea continues) or Famotidine 20mg slow IVP
  - \* Headache, pain or fever > 100.4°F - Acetaminophen 500mg 1-2 tablets PO as a single dose or Ibuprofen 400mg PO as a single dose
  - \* Hypotension (90/60) - place patient in reclined position, administer 0.9% NaCl IV 500ml, may repeat to keep BP > 90/60, monitor vital signs
  - \* Hypertension (> 30mmHg above baseline or > 180mmHg SBP) - Clonidine 0.1mg and wait 45 minutes, may administer amlodipine 5mg if hypertension persists
  - \* Chest pain/discomfort or shortness of breath - Oxygen 2-15 liters, titrate to keep SPO<sub>2</sub> ≥ 92%
  - \* May give Famotidine 20mg IV or Methylprednisolone 125mg IV - refractory to other treatments given
- May resume infusion when symptoms resolve at 50% previous rate and increase per manufacturer guidelines

### Severe allergic/anaphylactic reaction management

- Obtain a thorough allergy and drug history, note any cross-sensitivity
- Identify risk factors for anaphylaxis including history of severe drug reactions and family history of same, when administering blood/blood components and the first dose of an infusion medication.
- Identify and respond to signs/symptoms of anaphylaxis which is the likely type of reaction when all of the following criteria are met:
  - \* Sudden onset and progression of symptoms
  - \* Life-threatening airway / breathing / circulatory symptoms, such as laryngeal edema, stridor, severe dyspnea / wheezing, confusion, signs of shock, tachycardia, hypotension, cardiac arrest
  - \* Skin changes or changes in mucosa, such as flushing urticaria, angioedema
- Symptoms associated with less severe systemic reactions may include
  - \* Neurological - dizziness, headache, weakness, syncope, seizures
  - \* Psychiatric - anxiety
  - \* Respiratory - dyspnea, wheezing, bronchospasm, tachypnea
  - \* Cardiovascular - tachycardia, hypotension, arrhythmias
  - \* Cutaneous - flushing erythema, pruritis, urticaria, angioedema
- Interventions
  - 1) Stop infusion immediately
  - 2) Discontinue any medication suspected of causing reaction
  - 3) Initiate basic life support as needed
    - \* Initiate rapid response team, "Code"
  - 4) Utilize the 'Emergency Management of Anaphylaxis' in the Reaction Management Kit to follow steps for correct management of reaction.
  - 5) Perform interventions and treatments as ordered or according to organizational protocol
  - 6) Administer emergency medications - medications will include
    - \* Epinephrine
    - \* Corticosteroids - methylprednisolone 40mg or 125mg IV
    - \* Antihistamines - Diphenhydramine 25 - 50mg IV
    - \* IV fluids - 0.9% NaClResuscitation equipment will include
    - \* Barrier mask for CPR
    - \* Self-inflating bag for CPR maskBreathing support
    - \* Oxygen and delivery system or device
  - 7) Monitor patient's vital signs. Monitor and observe patient for at least 6 hours
  - 8) Patient may require transfer to ER department for observation period
- Documentation - document in the patient's health record
  - \* Presence of allergies/reactions
  - \* Observations and patient assessment
  - \* Licensed practitioner notification
  - \* Interventions taken and outcome
  - \* Patient condition and response to interventions