POYC
PHARMACY OF YOUR CHOICE

OMALIZUMAB REQUEST FORM

PATIENT DETAILS

Patient's Name and Surname: _____

Date of Birth: _____ **I.D. Card No:** _____

Address: _____

Age: _____ **Tel/Mob No:** _____

SECTION A

Schedule V Condition: ☐ Chronic Asthma

SECTION B (New Patients)

Omalizumab should be reserved for patients meeting ALL the following criteria:

☐	Used as add-on therapy for severe persistent asthma that remains inadequately controlled despite best available therapy
☐	Patient has IgE Mediated Asthma with IgE levels $\geq$ 76 IU/mL in adults and adolescents, or $\geq$ 200 IU/mL in children (6-12 years). If IgE levels are less than these values, an unequivocal in vitro reactivity (RAST) to a perennial allergen is required. **(Test result/s must be attached)**
☐	Patient has a positive skin test or in vitro reactivity to a perennial aeroallergen. **(Test result must be attached)**
☐	Reduced lung function (FEV_1 <80%)
☐	Frequent daytime symptoms or night-time awakenings
☐	Multiple documented severe asthma exacerbations despite daily high-dose inhaled corticosteroids, plus a long-acting inhaled $beta_2$ –agonist.

SECTION C (Renewal after 16 weeks of treatment)

After 16 weeks of commencing omalizumab therapy, patients should be assessed for treatment effectiveness before further injections are administered. Renewal of treatment will only be approved if patient meets ALL the following criteria:

☐	Patient is compliant with the treatment
☐	Marked improvement in overall asthma control is seen

SECTION D (Renewal after 12 months of treatment and other further renewals)

Renewal of treatment will only be approved if patient meets ALL the following criteria:

☐	Patient is compliant with the treatment
☐	Patient is benefitting from the treatment

_____ Signature of Consultant

_____ Name in Block Letters and Medical Council Reg. Number

_____ Date

_____ Countersignature by Clinical Chairman Paediatrics or Lead Consultant Respiratory Physician

For office use only:

Approved ☐
Not Approved ☐

_____ Pharmacist's Signature

_____ Name in Block Letters

_____ Date

Kindly fill ALL required sections

Data Protection Statement
All personal data is required to provide you with health care services as necessary, and is processed in accordance with the Data Protection Act, and as permitted by law. Further information about your data can be obtained on request.