certified
ALLERGY & ASTHMA
consultants

CONSENT TO RECEIVE XOLAIR® INJECTIONS

_____ _____
Patient's Name Record No.

Dr. _____ has discussed the recommendation that I (my child) receive Xolair® injections on a regular basis for treatment of asthma, chronic hives, nasal polyps or food allergy.

The potential side effects have been explained to me and I have had an opportunity to ask questions about this and other forms of treatment. I understand that the most common side effects of Xolair, as reported in clinical trials were local reactions at the injection site: bruising, redness, swelling, itching, pain, and inflammation. Less common side effects included: viral infections, upper respiratory infections, sinusitis, headache and sore throat. There may also be a slightly increased risk of various cancers; mini strokes, known as TIA's; heart attacks; sudden, unexpected chest pain; high blood pressure in the arteries of the lungs called pulmonary hypertension; and blood clots in the lungs and veins.

Although very rare, there is a risk of an anaphylactic (life threatening) reaction to Xolair injections. Even more rarely, this may be delayed for as long as 24 hours or more after receiving Xolair. For this reason, I will have an EpiPen available for use on the day I receive Xolair and the day after. Also reported in 0.5% of clinical trial patients were incidents of cancer compared to 0.2% of patients in the control group.

The effects of Xolair in pregnancy are unknown; therefore, I agree to advise the physician's office in the event of pregnancy or a plan to become pregnant. I understand that Xolair may reduce the need for other medications; however, I will continue to use/administer current medications as prescribed unless otherwise advised by the physician.

Because of the potential side effects described above, I agree to wait in the physician's office for **2 hours** after the first three injections and **30 minutes** after each subsequent injection. I will also report any reactions experienced after leaving the office. While treatment for a reaction that occurs during the waiting period is administered in the office, a severe reaction may require transport to an emergency room for further treatment. The monitoring of prolonged or delayed symptoms may also necessitate transfer to an emergency room.

In signing this consent, I acknowledge that I have read and understand the above information, and that my physician has satisfactorily answered my questions.

I also authorize the release of necessary medical information to third parties to obtain payment approval for the medication from my insurance company, and to the ordering of the medication on my behalf for delivery to the physician's office. If my health insurance company requires me to pay a portion of the cost of the medication, I understand I may need to do so prior to the medication being ordered.

_____ _____
Patient's (Parent/Guardian) signature Date

See reverse side for additional consent (minors age 16 and over) if applicable.

Additional Consent for minors age 16 and over, if applicable.

As parent (guardian) of _____ I acknowledge that he/she is at least 16 years of age. I hereby consent to him/her receiving Xolair injections at Certified Allergy & Asthma Consultants unaccompanied by a parent or guardian. Further, I authorize treatment as deemed necessary including the administration of medications to alleviate systemic reactions, without the presence of a parent or guardian. This consent shall remain valid until revoked by me in writing.

_____
Patient's (Parent/Guardian) signature

_____
Date

Rev. 03/2024