

XOLAIR THERAPY PATIENT CONSENT

I, _____ am acknowledging that I will begin my Xolair treatment.
(Print name legibly)

The following points regarding Xolair were reviewed and discussed in great detail:

- a. The nature and purpose of Xolair treatment program
- b. The risks of the treatment, including the possibility of an allergic reaction as well as the risk that the treatment program may not accomplish the desired objectives
- c. The possible outcome of the treatment
- d. The available alternative medical treatment
- e. The prognosis if the program is not followed
- f. The need for regular therapy and follow up, including the need to evaluate my asthma by keeping records of my medication use, symptoms and need for unscheduled care
- g. Risk of anaphylaxis and epinephrine use, with proper demonstration of epinephrine auto injector
- h. Office policies regarding Xolair (i.e. calling ahead for mixing and scheduled office visit required prior to administration if experiencing increase in asthma symptoms)

I have had sufficient opportunity to discuss my condition with my allergist and all of my questions have been answered to my satisfaction. I have read and understand the Xolair treatment information form. I believe that I have the adequate knowledge upon which to base an informed consent to this program.

I consent to other diagnostic and therapeutic procedures and the monitoring program that the physician decides might be necessary due to unexpected conditions (such as treatment of an allergic reaction).

I have read and fully understand this form.

PATIENT _____

DATE _____

PARENT or LEGAL GUARDIAN _____

DATE _____

WITNESS _____

DATE _____

Patients on Xolair should have an office visit with prescribing allergist (Dr. <Last name>) every 6 months and pulmonary function tests every 1-2 years at minimum, or if there has been an increase in asthma symptoms or to assess response to treatment.