(omalisumab)

XOLAIR Infusion Orders

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

☐ _____Allergic Asthma
☐ _____Chronic Idiopathic Urticaria
☐ _____(Other)

PRE-MEDICATION:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____Other

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____Other

XOLAIR ORDERS:

DOSAGE

⬭ **150mg** ⬭ **225mg** ⬭ **300mg** ⬭ **375mg**

● ***Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy***

FREQUENCY:

⬭ **Every 2 weeks** ⬭ **Every 4 weeks**

PATIENT WEIGHT

_____**LBS**
_____**KG**

ALLERGIC ASTHMA HISTORY:

☐ **Positive RAST or Skin test** **Test Date:** _____
☐ **Pre-treatment Serum IgE** **Lab Date:** _____

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Administer injection as ordered

ORDERING PROVIDER:

Signature _____ **Printed Name:** _____**Date**_____

Practice _____**Phone**_____ **Fax** _____

PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058

REV: 3/2023