# Omalizumab (Xolair)

**Provider Order Form rev.** 10/30/2023

## PATIENT INFORMATION

**Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

## DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Asthma: Chronic Rhinosinusitis: Chronic spontaneous urticaria:

Other: Description:

## THERAPY ADMINISTRATION

☑ Administer Xolair subcutaneously. Divide doses exceeding 150mg among multiple injection sites to limit injections to not more than 150mg per site.

☑ Following the first three injections, monitor the patient for post-injection observation period of 2 hours. For all subsequent injections, monitor patient for 30 minutes.

## DOSING *(Choose one)*

For Chronic Spontaneous Urticaria: ☐ 150mg / ☐ 300mg

For Asthma/Chronic Rhinosinusitis: _____ mg *(dose based on IgE levels and weight)*

## FREQUENCY

☐ Every _____ weeks

## ADDITIONAL ORDERS

## LABORATORY ORDERS

☐ Other: _____

## PRE-MEDICATION ORDERS

☐ Other: _____

## NURSING

☑ Hold infusion and notify provider for reports signs or symptoms of serum sickness (fever, rash, joint pain/swelling/stiffness, muscle pain, swollen lymph nodes)

☑ Confirm patient has epinephrine auto-injector if required and understands indications for use.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

## REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, & number of flares per year

**Required Labs:** Skin test, IgE

**Provider Name *(print)*** **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.