P: (360) 933-4892
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www.infusionsolutionsinc.com

XOLAIR (omalizumab) ORDER FORM

PATIENT NAME: ______________________________________ DOB: __________________ WT: ________ HT: _________

ALLERGIES: ____

DIAGNOSIS

HAS THE PATEINT PREVIOUSLY RECEIVED: XOLAIR (omalizumab) ❒NO ❒YES - LAST DOSE DATE: _____________

DIAGNOSIS: ______________________________________ ICD 10 CODE(S):____________________________________

MEDICATION ORDERS

DOSE:

- ❒ 75 mg subcutaneous injection
- ❒ 150 mg subcutaneous injection
- ❒ 225 mg subcutaneous injection
- ❒ 300 mg subcutaneous injection
- ❒ 375 mg subcutaneous injection
- ❒ Other: ____________________

FREQUENCY:

- ❒ Every 2 weeks
- ❒ Every 4 weeks
- ❒ Other: ____________________

Maintenance orders are valid for 1 year. For shorter duration, indicate here: __________

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- Monitor vital signs (temp, HR, RR, BP) before therapy.
- Observe patient for 15 minutes after completion of therapy.

LABS

LAB ORDERS:

- ❒ CBC w/ diff
- ❒ CMP
- ❒ Serum IgE
- ❒ Other: _________________
- ❒ Labs will be managed and monitored by prescriber

LAB FREQUENCY:

- ❒ Every dose
- ❒ Other: ____________________

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Serum IgE levels

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline CMP, CBC w/ diff
- Documentation if patient has a parasitic infection
- Documentation if patient has cancer

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution)

PRESCRIBER SIGNATURE (dispense as written)

PRINT NAME (FIRST AND LAST)

DATE