SPECIALTY
INFUSION CENTER
An Access Infusion Care Company

# XOLAIR (OMALIZUMAB) ORDERS

## PATIENT INFORMATION

Name: ______________________ DOB: __________ Height: ________ Weight: ________

Address: ______________________ Phone: ______________ Allergies: ____________

City, State, Zip: ______________________ Email: ______________________

## REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: ____________ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

## DIAGNOSIS AND ICD-10 CODE

☐ Severe Eosinophilic Asthma ICD-10 Code: ______________

☐ Chronic Idiopathic Urticaria ICD-10 Code: ______________

☐ Chronic Rhinosinusitis with Nasal Polyps ICD-10 Code: ______________

☐ Other: ______________ ICD-10 Code: ______________

## REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Pulmonary Function Tests (asthma only)

☐ Serum IgE level

☐ H&P and Clinical Progress note supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

☐ Perennial aeroallergen test or skin test results (asthma only)

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

## MEDICATION ORDERS

| Dosing | Dose in 75mg increments based on the pretreatment eosinophil count and actual body weight.<br>☐ Xolair ________ mg SubQ every 2 weeks ☐ Xolair ________ mg SubQ every 4 weeks |
|---|---|

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: __________

*(if not indicated, order will expire 1 year from date signed)

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: ______________________

## PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion

☐ Diphenhydramine 25mg PO prior to infusion

☐ Other: ______________________

☐ Other: ______________________

## EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

**Adults (weight >40kg):**

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

**Pediatrics (weight <40kg): (may adjust with weight changes)**

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

## PRESCRIBER INFORMATION

Prescriber Name: ______________________ NPI Number: ______________

Office Phone: ______________ Office Fax: ______________

Prescriber Signature: ______________________ Date: ______________

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Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
Fax: (855) 857-3834

Marquette, MI
Phone: (906) 661-1088
Fax: (855) 857-3834