MEDICATION ORDERS

XOLAIR (OMALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICD 10 CODE

☐ Severe Eosinophilic Asthma ICD 10 Code: J45.50
☐ Chronic Idiopathic Urticaria ICD 10 Code: L50.1
☐ Other: _____ ICD 10 Code: _____

REQUIRED DOCUMENTATION/TESTING

☐ This signed order form by the provider
☐ Patient demographics AND insurance information
☐ Pulmonary Function Tests (asthma only)
☐ Perennial aeroallergen test or skin test results (asthma only)
☐ Clinical/ Progress notes, including H&P
☐ Labs and tests supporting primary diagnosis
☐ Serum IgE level (Asthma Only)

List tried AND failed therapies, including duration of treatment:
1)

2)

3)

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Severe Eosinophilic Asthma Dosing: Please indicate dose, in increments of 75mg, based on pretreatment eosinophil count and body weight.
☐ Xolair _____ mg subQ injection every 2 weeks
☐ Xolair _____ mg subQ injection every 4 weeks

Chronic Idiopathic Urticaria Dosing:
☐ Xolair 150mg subQ injection every 4 weeks
☐ Xolair 300mg subQ injection every 4 weeks

Refills: ☐ x 6 months ☐ x 1 year ☐ _____ doses

Treatment Labs:
- ✓ Pregnancy test within 72 hours prior to initiation of therapy for female patient under 55 years of age and no history of surgical hysterectomy

- New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.
- Please note for patients receiving treatment at the Montgomery Cancer Center: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.
- Please note for patient receiving treatment at Baptist East Outpatient Infusion: if an infusion reaction occurs, the Baptist East staff will follow the PRN hypersensitivity standing orders and will contact the referring provider in the event of an emergency. For life threatening anaphylaxis, Baptist East staff will follow rapid response policy or 911 facility policy.

Physician Signature: Date:

Patient Name: _____ Patient Date of Birth: _____

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All order sets will include a statement to activate these PRN hypersensitivity standing orders when necessary.

REACTION SYMPTOMS		DRUG	DOSE	ROUTE
Fever, chills and or rigors	✓	Acetaminophen (Tylenol)	1000mg	PO
Itching, facial flushing, hives, rash	✓	Diphenhydramine (Benadryl)	50mg	IVP
	✓	Famotidine (Pepcid)	20mg	IVP
	✓	Methylprednisolone (Solu-Medrol)	125mg	IVP
Hypotension, wheezing, shortness of breath, facial/lip/tongue swelling	✓	Normal Saline	150ml/hr	IV
	✓	Diphenhydramine (Benadryl)	50mg	IVP
	✓	Methylprednisolone (Solu-Medrol)	125ng	IVP
	✓	Hydrocortisone (Solu-Cortef)	50mg	IVP
	✓	Epinephrine Pen	0.3mg	IM
Nausea/Vomiting	✓	Granisetron (Kytril)	1mg	IVP

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Physician Signature:	Date:		

For questions, please contact
Baptist Outpatient Infusion Services @ (334) 747-7401

Fax completed form and all documentation to
Baptist Outpatient Infusion Services @ (334) 747-7403