PREMIER INFUSION CENTER

📜 Xolair (omalizumab) Injection Order Form

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👤 Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ kg **Height:** _____ cm/in
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

🔹 Diagnosis (ICD-10 Selection)

☐ J45.50 – Severe persistent asthma, uncomplicated
☐ J45.40 – Moderate persistent asthma, uncomplicated
☐ L50.1 – Chronic idiopathic urticaria
☐ J33.8 – Other polyp of sinus
☐ Other: _____ **ICD-10 Code:** _____

🔹 Injection Order

- **Dose Options (based on weight and IgE level):**
  ☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg ☐ 375 mg ☐ 450 mg
  ☐ 525 mg ☐ 600 mg
- **Route:** Subcutaneous injection
- **Frequency:**
  ☐ Every 2 weeks ☐ Every 4 weeks ☐ Other: _____
- **Observation:**
  ☐ 30 minutes post-injection (initial doses)
  ☐ 15 minutes post-injection (maintenance)
- **EpiPen Requirement:**
  ☐ Patient must carry EpiPen
  ☐ EpiPen not required

- **Refills:** ☐ None ☐ 12 months ☐ Other: _____

🔹 Required Labs & Documentation

☐ Serum total IgE level (pre-treatment)
☐ Positive RAST or skin test (for allergic asthma)
☐ CBC ☐ CMP ☐ Spirometry (FEV1/FVC)
☐ Other: _____
☐ Physician office will order labs only

🔹 Premedication (Optional)

☐ Acetaminophen: ☐ 650 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Loratadine: ☐ 10 mg ☐ PO
☐ Famotidine: ☐ 20 mg ☐ IV
☐ Methylprednisolone: ☐ 125 mg ☐ IV
☐ Other: _____ **Dose:** _____ **Route:** _____

🔹 Clinical Documentation Checklist

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
☐ Documentation of prior therapies, intolerance, or contraindications
☐ IgE level and allergen testing results

🔹 Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / _____ / _____