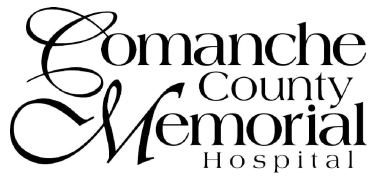

Outpatient Infusion Center
Xolair Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender: M F

Patient Address: Email: Insurance:

Additional Information Needed

- Fax front/back of insurance card
- Fax patient demographics
- Fax clinical/progress notes
- Fax current medication list
- Fax labs
- Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

- J45.40 Moderate Persistent Asthma, Uncomplicated (6 Years of age and older)
- J45.50 Severe Persistent Asthma, Uncomplicated (6 years of age and older)- Uncontrolled with Inhaled Corticosteriod? Yes or No
- L50.1 Idiopathic Urticaria (12 years of age and older)- Symptomatic Despite H1 Antihistamine Treatment for 6 weeks? Yes or No
- Other: DX: ____________________

Clinical Information:

- New Therapy Induction
- Therapy Change
- Therapy Continuation

Patient Weight:________ lbs/ ________ kg Patient Height: ________ in/_______ cm

Allergies:____________________

Therapies Tried and Failed: ____________________

TB Test: Date: ___________Results: __________________ Hep B Test: Date:___________ Results:__________________

Date of Last Xolair Injection:__________________

Does the patient have a history of severe hypersensitivity reaction to previous dose of Xolair or any ingredient of Xolair? Yes or No

Has the patient had a positive skin test to perennial aeroallergen? Yes or No

Has the patient had a positive RAST test? Yes or No

Has the patient had pre-treatment IgE serum? Yes or No

Lab Orders

CBC w/o diff CMP ESR CRP Total IgE

Other: ____________________

Lab Orders to be done by

- Infusion Services
- Referring Provider

Prescription Information

Xolair

Administration: Vial (Lyophilized Powder) PFS (Prefilled Syringe)

Dose: 75mg 150mg 225mg 300mg 375mg

Frequency: 2 weeks 4 weeks

Misc Orders

____

____

PICC/Midline/CAD dressing to be changed every 7 days

Flushes

- 10mL NS Flush Syringe PRN
- Heparin 500units/5mL Flush Syringe PRN
- 50ml NS Bag PRN
- 250ml NS Bag PRN

Standing Orders for Adverse Reaction

- Stop infusion and initiate NS bolus
- Notify Supervising physician and ordering provider
- Solu-Cortef 100mg SIVP signs of adverse reaction
- Benadryl 25 mg SIVP for hives or bronchial inflammation
- Epi 1:1000 1mL IM, IV or SQ for anaphylaxis
- Oxygen 2-5L nasal cannula
- Albuterol 2.5mg inhaled PRN to chest tightness
- Other: ____________________

Prescriber Information

Physician Name: ____________________ Official Contact Name: ____________________

Contact #: ____________________ Fax Number: ____________________

Address: ____________________ City/State/Zip: ____________________

NPI#:__________________ DEA#: __________________ State License #: ____________________

____________________ ____________________

Physician's Signature Date Time