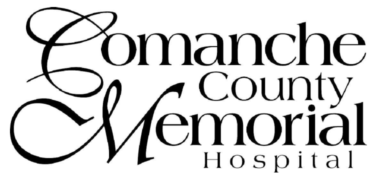

Outpatient Infusion Center
Xolair Order

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