ORDERING OFFICE, ALSO FAX:

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

Omalizumab (Xolair)

Provider Order Form

OIS Ohio Infusion Services

Date:	Patient Name:	DOB:
ICD-10 code (required): ☐ J45.50 (severe persistent asthma, uncomplicated) ☐ L50.8 (Chronic urticaria) ☐ Other:		
If Other, give ICD-10 description:		
☐ NKDA Allergies:		Weight lbs/kg:
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City:	State: Zip Code:

INJECTION THERAPY

☑ Omalizumab (Xolair)

- Dose: ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg
- Route: subcutaneous injection
- Frequency: ☐ every 2 weeks ☐ every 4 weeks / ☐ other: _____

Refills: ☐ Zero / ☐ for 12 months / ☐ _____

OBSERVATION/EPI PEN (PLEASE SELECT BELOW)

☐ Patient is required to have Epi Pen with each treatment
☐ Patient is NOT required to have Epi Pen
☐ Patient is required to stay for 30 minutes observation post injection
☐ Patient is NOT required to stay for observation time
☐ Other:

GENERAL PLAN COMMUNICATION

Special instructions/notes:

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT

☐ Observe for **hypersensitivity reaction:** Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
☐ If reaction occurs:
- Stop infusion
- Maintain/establish vascular access
- Notify referring provider
- Consider giving the following PRN
  1. Acetaminophen (Tylenol) 650mg PO **OR**_____mg for pain or fever > 38 C/100.4 F
  2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
  3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
  4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
  5. Methylprednisolone (Solumedrol) 125mg **OR** _____mg slow IV push.
  6. Other _____
- When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines

☐ **Severe allergic/anaphylactic reaction:**
- If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
  1. Call 911
  2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
  3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
  4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
  5. Have Automated External Defibrillator available
  6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
  7. Discontinue treatment

Determine dose (mg) and dosing frequency by serum total IgE level (IU/mL) measured before the start of treatment, and by body weight (kg). Because of the risk of anaphylaxis, observe patients closely for an appropriate period of time after XOLAIR administration.

Patient Name _____ **Patient Date of Birth** _____

Provider Name (Print) _____

Provider Signature _____ **Date** _____

Please fax the order form to (440) 443-0700

OIS Ohio Infusion Services