



Omalizumab (XOLAIR)

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Name: _____

DOB: _____ Phone: _____

Gender: Male Female

Allergies: _____

DIAGNOSIS (ICD-10 code required):

- _____ Asthma
- _____ Nasal Polyps
- _____ Chronic Idiopathic Urticaria (CIU)
- _____ Other: _____

PROVIDER REMINDERS:

- All orders with a will be placed unless otherwise noted
- Serum IgE level required before initiation of treatment for Asthma & Nasal Polyps, not required for Chronic Idiopathic Urticaria (CIU)

TREATMENT CRITERIA:

Hold Omalizumab (XOLAIR) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Severe hypersensitivity reaction to Omalizumab (XOLAIR)

Nursing Considerations:

- The injection may take 5-10 seconds to administer because the solution is slightly viscous.
- For the first 3 injections, monitor for adverse reaction including vital signs and pulse ox, every 30 minutes post injection for two hours. Reduce observation period to 30 minutes for the 4th and subsequent injections. If the patient refuses to stay for the recommended observation period, he or she must sign a waiver.
- Do not administer more than 150mg per injection site.

Premedications

- No routine premeditations necessary.**
- _____
- _____

Medications

Patient Weight _____ kg **(REQUIRED)**

Inject **Omalizumab (XOLAIR)**

Dose:

_____ mg

Frequency:

Every 2 weeks

Every 4 weeks

- INFUSION REACTION MEDICATIONS** per Standardized Procedures
- TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Special Instruction(s):

Provider Signature _____ Date _____ Email _____

Printed Name _____ Phone _____ Fax _____

Office Contact _____ Phone _____ Email _____