(omalizumab)

XOLAIR injection orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ __________ Allergic Asthma

☐ __________ Chronic Idiopathic Urticaria

☐ __________ ______________________________ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ ______________________________ *(other)*

☐ Length of Need ______________

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ ______________________________ *(other)*

XOLAIR ORDERS

DOSAGE

◉ 150mg ○ 225mg ○ 300mg ○ 375mg

FREQUENCY

○ every 2 weeks ○ every 4 weeks

ALLERGIC ASTHMA HISTORY

☐ Positive RAST or Skin Test

☐ Pre-treatment Serum IgE:

PATIENT WEIGHT

________ lbs.

________ kg

Refills: ______________

Test Date: ________

Lab Date: ________

Notes

____

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________

Address ____

____

NPI# ______________________

DEA# ______________________

FAX ORDERS: 702-780-4887