6415 Fort Apache Road, Suite #175
Las Vegas, NV 89148
Phone: 702-665-5730
Fax: 702-780-4887

Xolair (omalizumab) **Infusion Orders**

Patient Name: ____ Date of Birth: ____________________
Address: ____ Phone Number: __________________
Gender: _______ Height: _____ Weight: _____ (lb/kg)

Diagnosis

☐ _____ Allergic Asthma
☐ _____ Chronic Idiopathic Urticaria
☐ ______________________________________
☐ ______________________________________

Pre-Medication

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125 IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ________________________
☐ ________________________

Orders

Dosage
☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg

Frequency
☐ every 2 weeks
☐ every 4 weeks

_________ Refills

Notes

____
____
____
____
____
____

Ordering Provider

Signature: ____Date: _____________________
Provider:_______________________________________ Phone: _________________ Fax: _________________
Address: ____
NPI: ____ DEA: ____