MHS Home/Alternate Site Infusion Services
Omalizumab (Xolair) Injection Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name:	**DOB:** _____/_____/_____	**Weight:** _____ lb/kg
Patient Phone Number: (_____) _____-_____	**Requested Date of Service:** _____/_____/_____	

Patient Allergies:

Diagnosis: _____ **ICD – 10 Code:** _____

Baseline Labs *(Required)***:**
- IgE level Date: _____/_____/_____ Result: _____

Patient weight: _____lb/kg required for allergic asthma diagnosis (not needed for chronic idiopathic urticaria)

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for Omalizumab (Xolair) Injection

ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Pre-Medication(s): none required
***Patient must carry an epinephrine auto-injector in the event of anaphylaxis*

Biologic Injection:
Omalizumab (Xolair) Dosing:
- □ 150 mg SUBQ □ every 2 weeks or □ every 4 weeks
- □ 300 mg SUBQ □ every 2 weeks or □ every 4 weeks
- □ _____ mg SUBQ □ every 2 weeks or □ every 4 weeks

Skilled Nurse to draw labs as follows:
- □ Lab(s) _____ Frequency: _____

Skilled Nurse Interventions:
- Admit *(first visit)* patient to services for home infusion therapy of Omalizumab (Xolair).
- Complete Skilled Nurse visit with each injection for ongoing home infusion therapy of Omalizumab (Xolair).
- Obtain vital signs (TPR & B/P) at baseline and 30 minutes post-injection.
- Obtain patient weight at each visit.
- Draw labs as ordered.
- Inject Omalizumab (Xolair) as prescribed.
- If vital signs are stable for at least 30 minutes after injection, Skilled Nurse will complete visit. If no injection-related events with previous 3 doses, may waive post-injection monitoring period and discharge pt home after completion of injection.

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<u>If Hypersensitivity Reaction Develops</u> (fever, chills, hypotension, rigors, itching, rash, etc.):
The Skilled Nurse will:

- Administer emergency medications as prescribed (*below*).
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number**)** for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

<u>Emergency Medications</u>: To be administered by Skilled Nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access is available.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access is available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:	**Return completed orders to:**
Address: _____	MultiCare Home/Alternate Infusion Services 253-459-6650 (*phone*) / 253-864-2785 (*fax*)
Phone #: _____ Fax#: _____	

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