ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

❑ Allenmore Infusion Center
❑ Auburn Infusion Center
❑ Gig Harbor Infusion Services
❑ Puyallup Infusion Center
❑ DHEC Infusion Center
❑ North Spokane Infusion Center
❑ North Star Lodge Infusion Center

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

Omalizumab (Xolair)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

ICD -10 Code:

Diagnosis:
❑ Allergic Asthma (see lab requirement) ❑ _____
❑ Chronic Idiopathic Urticaria ❑ _____
❑ Other _____ ❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline lab required for initial dosing for diagnosis of allergic asthma:

- IgE level Date_____ Results_____

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

Patient must carry an epinephrine auto-injector in the event of anaphylaxis

Treatment Regimen:

Omalizumab (Xolair) given SQ:

❑ 150 mg SQ ❑ every 2 weeks or ❑ every 4 weeks
❑ 300 mg SQ ❑ every 2 weeks or ❑ every 4 weeks
❑ Other_____ mg SQ ❑ every 2 weeks or ❑ every 4 weeks

☑ **Vital Signs:** Check vital signs prior to and after injection.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

☑ **Special instructions:** If stable 30 minutes post injection, may discharge home. If no injection-related events with previous 3 doses may waive post-injection monitoring period and discharge patient home after completion.

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

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)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
OMALIZUMAB (Xolair)

MultiCare

78-0049-4MR (Rev. 9/24)