HONORHEALTH

OMALIZUMAB

(Xolair)

Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order	☐ Renewal	☐ Dose or Frequency Change
Allergies:		**Weight:** **Height:**	
Diagnosis	☐ Asthma, moderate to severe allergic ☐ Chronic spontaneous urticaria ☐ Nasal polyps ☐ Other:	**Diagnosis Code:**	
Required Information	CBC, CMP (please include lab result documents)	Date:	
Labs	☐ CBC, CMP every:	☐ Other:	

Required Documentation

- Asthma: Pre treatment IgE level greater or equal to 30 IU/mL.
- Nasal Polyps: Bilateral nasal endoscopy, anterior rhinoscopy or CT or Melzter clinical score of 2 or higher in each nostril or NPS of at least 5 with a minimum score of 2 for each nostril.
- Continuation for Asthma: Asthma control improvement on Xolair. Reduction in the frequency/severity of symptoms, exacerbations or, reduction in daily maintenance oral corticosteroid; and continued use of asthma treatment in combination with Xolair and; not be used concomitantly with other biologics indicated for asthma.

Pre-Medications

☐ Diphenhydramine ○ PO ○ IV ○ 25 mg ○ 50 mg

☐ Acetaminophen ○ 325 mg ○ 650 mg

☐ Other:

Medication Order

☐ Xolair 150 mg SQ once every _______ weeks

☐ Xolair 300 mg SQ once every _______ weeks

☐ Xolair 375 mg SQ once every _______ weeks

☐ Other:

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: