(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)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

XOLAIR ORDERS

DOSAGE

150mg 225mg 300mg 375mg

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

every 2 weeks every 4 weeks

ALLERGIC ASTHMA HISTORY:

- ☐ Positive RAST or Skin Test Test Date: _____
- ☐ Pre-treatment Serum IgE: Lab Date: _____

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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