RED RIVER HEALTH
Ambulatory Infusion Clinic

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XOLAIR (omalizumab) Injection Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Allergic Asthma

☐ _____ Chronic Idiopathic Urticaria

☐ _____ _____ *(other)*

Pre-Medication:

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ Other: _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

Required Documents:

☑ Patient Demographic Sheet

☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*

☑ Current and tired & failed therapies *(please attach)*

☐ +RAST or Skin Test *(please attach)*

☐ Pre-treatment Serum IgE *(please attach)*

XOLAIR ORDERS:

Dosing: ☐ 150 mg SQ ☐ 225 mg SQ ☐ 300 mg SQ ☐ 375 mg SQ

Frequency: ☐ every 2 weeks ☐ every 4 weeks

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: