

Omalizumab (Xolair®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

| | | | |
|---|---|--|--|
| Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____ | Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____ | | |
| <p style="text-align: center;">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____ | <p style="text-align: center;">Labs</p> <input type="checkbox"/> Baseline serum total IgE <input type="checkbox"/> Other: _____ | | |
| Note to provider: Dose based on pretreatment serum IgE and patient weight | | | |
| Omalizumab (Xolair®) Subcutaneous Injection | | | |
| <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> Dose <input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 375 mg <input type="checkbox"/> Other: _____ </td> <td style="width: 50%; vertical-align: top;"> Frequency <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Other: _____ </td> </tr> </table> | | Dose <input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg <input type="checkbox"/> 300 mg <input type="checkbox"/> 375 mg <input type="checkbox"/> Other: _____ | Frequency <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Other: _____ |
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| Pre-Medications and Pre-Protocol (ordered at physician discretion) | <table style="width: 100%;"> <tr> <td style="width: 50%;"> <input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____ </td> <td style="width: 50%; vertical-align: top;"> <p style="text-align: center;">Hydration</p> <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other: _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following </td> </tr> </table> | <input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____ | <p style="text-align: center;">Hydration</p> <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other: _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following |
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| | | |
|---|---|--|
| Flushing Protocol <i>as needed for line care</i> | <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL | <input type="checkbox"/> Heparin 100 Units/mL <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL |
| Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary | <ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure | |
| <div> <div> Provider Name: _____ Attending Physician Name: _____ Office Phone Number: _____ <i>Note: This order is valid for 12 months from date of physician signature.</i> </div> <div> Provider Signature: _____ Provider NPI: _____ Office Fax Number: _____ </div> </div> | | |