Ascension
St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Omalizumab (Xolair) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.

-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List:	_____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Asthma, moderate to severe allergic ☐ Nasal Polyp ☐ Chronic spontaneous urticaria ☐ Other: _____	☐ J45.5 ☐ J33.9 ☐ L50.1 ☐ Other: _____	☑ J2357	☑ CPT Code: _____

Labs (prior to scheduling infusion)

☑ Serum IgE level

Nursing Orders

☑ Discharge patient when stable and meets protocol criteria

Emergency/Anaphylaxis Order

☑ Follow standard orders for management of allergies and anaphylaxis reactions

Pre-medications (not required)

☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☐ Dexamethasone 20 mg IV, once	☐ Other: _____
☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose		Frequency	Select Treatment Type
☑	Xolair	SQ	☐ 75 mg ☐ 150 mg ☐ 225 mg ☐ 300 mg	☐ 375 mg ☐ 450 mg ☐ 525 mg ☐ 600 mg	Once	☐ Every 2 weeks for ____ dose(s) ☐ Every 4 weeks for ____ dose(s) ☐ Other: _____

Order Comments: *Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			