Ascension Rx

Omalizumab (Xolair & Biosimilars) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☐ Serum IgE
  - ☐ Maintenance (every _____)
    - ☐ Serum IgE
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Nursing Order

- ☑ Do not administer Omalizumab with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

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Medication Orders (select only one)

☐ Omalizumab _____ mg SQ once every 2 weeks

☐ Omalizumab _____ mg SQ once every 4 weeks

☐ Omalizumab _____ mg SQ once every _____ weeks

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:
☐ Payer-mandated substitution
☐ Financial stewardship
☐ Patient access / hardship

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Administer subcutaneous injection into the thigh or abdomen, avoiding the 2-inch (5 cm) area directly around the navel. The outer area of the upper arms may be used only if the injection is being given by a caregiver or healthcare provider.

Monitor patients for 2 hours after the first 3 injections and for 30 minutes after subsequent injections.

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated