Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____
Height_____ Weight_____
Infusion Location: (state and Site) _____

Xolair® (omalizumab) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Allergic asthma (ICD-10)

_____ Chronic spontaneous urticaria (ICD-10)

_____ Other: _____ (ICD-10)

- ❑ **Provider**: Check to confirm patient has received epinephrine auto-injector & has been educated on use

IgE Result/Date: _____

Nursing Orders:

-Hold treatment and notify provider if patient:

- Reports signs or symptoms of serum sickness (fever, rash, joint pain/swelling/stiffness, muscle pain, swollen lymph nodes)
- Has **not** received epinephrine auto-injector and education on its use

Xolair _____mg subcutaneously. Divide doses exceeding 150 mg among multiple injection sites to limit injections to not more than 150 mg per site.

Dosing:

For Asthma/Chronic Rhinosinusitis dose based on IgE levels and weight

For Chronic Spontaneous Urticaria flat dose of 150mg or 300mg

Frequency: Every _____ weeks

Observation Period:

- Following the first three injections, monitor patient for post-injection observation period of 2 hours. For all subsequent injections, monitor patient for 30 minutes.
- Record vital signs prior to discharge.
- **If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol to include administration of epinephrine 0.3 mg IM STAT.**

Additional Orders:

Provider name (print)_____ Date:_____

Provider signature: _____ Time: _____

Reviewed 5/3/23 Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.