Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Xolair® (omalizumab) Orders

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

_____ Allergic asthma (ICD-10)

_____ Chronic idiopathic urticaria (ICD-10)

_____ Other: _____ (ICD-10)

Provider: Please check here ☐ to confirm patient has received epinephrine auto-injector and has been educated on its use

Patient Weight: _____ 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

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

Observation Period:

☑ Following 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.**

Frequency:

☑ Every _____ weeks

Additional Orders:

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____

Revised 8/1/19. Order valid for one year unless otherwise indicated.