BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

XOLAIR (OMALIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Severe Eosinophilic Asthma ICD-10 Code: _____

☐ Chronic Idiopathic Urticaria ICD-10 Code: _____

☐ Chronic Rhinosinusitis with Nasal Polyps ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Pulmonary Function Tests (asthma only)

☐ Serum IgE level

☐ H&P and Clinical Progress note supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

☐ Perennial aeroallergen test or skin test results (asthma only)

List Tried & Failed Therapies, including duration of treatment:

1)
2)
3)

MEDICATION ORDERS

Dosing

Dose in 75mg increments based on the pretreatment eosinophil count and actual body weight.

☐ Xolair _____ mg SubQ every 2 weeks ☐ Xolair _____ mg SubQ every 4 weeks

Refills*: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

*(if not indicated, order will expire 1 year from date signed)

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion

☐ Diphenhydramine 25mg PO prior to infusion

☐ Other: _____

☐ Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Helena, MT
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