(omalizumab)

XOLAIR injection orders

Patient Name DOB

Phone M F

DIAGNOSIS *Please provide ICD-10 code*

Allergic Asthma

Chronic Idiopathic Urticaria

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

(other)

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

(other)

XOLAIR ORDERS

DOSAGE

150mg 225mg 300mg 375mg

FREQUENCY

every 2 weeks every 4 weeks

PATIENT WEIGHT

lbs.

kg

ALLERGIC ASTHMA HISTORY:

Positive RAST or Skin Test Test Date:

Pre-treatment Serum IgE: Lab Date:

NOTES

ORDERING PROVIDER

Signature **X** ________________________________ Date

Provider Phone Fax

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