



Omalizumab (Xolair®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes.

Trinity Health will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: _____

Referral Status: New Referral Dose or Frequency Change Renewal

Patient Name: _____ Date of Birth: _____ Weight: _____ kg Height: _____ cm Allergies: _____		Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____	
<p style="text-align: center;">Diagnosis</p> Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____		<p style="text-align: center;">Labs</p> <input type="checkbox"/> Baseline serum total IgE <input type="checkbox"/> Other: _____	
Pre-medications: No pre-medications are routinely given. Pre-medications may be ordered at physician discretion. <input type="checkbox"/> Other: _____			
Note to provider: Dose based on pretreatment serum IgE and patient weight			
<p>Rx Omalizumab (Xolair®) Subcutaneous Injection</p> Dosing: <input type="checkbox"/> 150mg <input type="checkbox"/> 225mg <input type="checkbox"/> 300mg <input type="checkbox"/> 375mg <input type="checkbox"/> Other: _____ Frequency: <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Other: _____			
Nursing orders: Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9% bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN			
Provider Name: _____ Office Phone Number: _____ Attending Physician Name: _____ <small>(If ordering provider is an advanced practice practitioner)</small> <small>Note: This order is valid for 12 months from date of physician signature.</small>		Provider Signature: _____ Office Fax Number: _____	