

Omalizumab (Xolair)

Provider Order Form rev.

06/17/2026

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

Asthma: _____ Chronic Rhinosinusitis: _____ Chronic spontaneous urticaria: _____
IgE Mediated Food Allergy: _____ Other(add description): _____

THERAPY ADMINISTRATION

- Administer Xolair subcutaneously. Divide doses exceeding 150mg among multiple injection sites to limit injections to not more than 150mg per site.
- Following the first three injections, monitor the patient for post-injection observation period of 2 hours. For all subsequent injections, monitor patient for 30 minutes.

DOSING (Choose one)

For Chronic Spontaneous Urticaria: 150mg / 300mg For
Asthma/Rhinosinusitis/Food Allergy: _____ mg
(dose based on IgE levels and weight)

Frequency

Every _____ weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

Other: _____

NURSING

- Hold infusion and notify provider for reports signs or symptoms of serum sickness (fever, rash, joint pain/swelling/stiffness, muscle pain, swollen lymph nodes)
- Confirm patient has epinephrine auto-injector if required and understands indications for use.
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, & number of flares per year
Required Labs: Skin test, IgE

Provider Name (print)

Provider Signature

Date

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.