Omalizumab (Xolair)

Provider Order Form rev.
10/21/2026

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 Foo Allergy: Other(add description):

THERAPY ADMINISTRATION

☑ Administer Xolair subcutaneously.
☑ 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

Anaphylaxis Prevention: (Recommended)
☐ Patient has an EpiPen to be used for this therapy.
☐ Rx for EpiPen has been sent to retail pharmacy.
☐ Patient does not require EpiPen for this therapy.

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.