Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Xolair (omalizumab) Non-Oncology Treatment Order Set

1. Patient Name: ____

2. DOB: _______________________________________ **Height (inches):** __________ **Weight (lbs):** _______________

3. Diagnosis:

[ ] J45.51 Severe persistent asthma with (acute) exacerbation [ ] J45.41 Moderate persistent asthma with (acute) exacerbation
[ ] J45.50 Severe persistent asthma, uncomplicated [ ] J45.40 Moderate persistent asthma, uncomplicated
[ ] J45.52 severe persistent asthma with status asthmaticus [ ] J45.42 Moderate persistent asthma with status asthmaticus
[ ] Other ICD-10 Code: ___________________ Diagnosis description: ____________________________

4. Pre-medications:

[ ] Acetaminophen:
[ ] **1000mg PO** [ ] **500mg PO**
[ ] Diphenhydramine:
[ ] **25mg PO** [ ] **50mg PO** [ ] **25mg IV** [ ] **50mg IV**
[ ] Hydrocortisone: 100mg IVP
[ ] Other Pre-medication: ____
[ ] No Pre-medications indicated

5. Drug Order:

Xolair (omalizumab) *Ok to substitute with generic/biosimilar*
[ ] Subcutaneously Every 2 weeks: [ ] 225mg/dose [ ] 300mg/dose [ ] 375mg/dose
[ ] Subcutaneously Every 4 weeks: [ ] 75mg/dose [ ] 150mg/dose [ ] 225mg/dose [ ] 300mg/dose
Special Instructions: ____
[ ] New to Therapy
[ ] Continuing therapy: Last Dose Received ____________________ Next Dose Due ___________________

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

6. Infusion Lab Requirements:

[ ] CBC with differential annually
[ ] Other: ____
[ ] No labs monitoring

HOA of CNY WILL NOT DRAW LAB WORK REQUIRED FOR INFUSION ADMINISTRATION.
The prescribing physician is responsible for ordering, obtaining, reviewing all laboratory results & providing copy to HOACNY prior to infusion as ordered above.

7. Baseline Lab/Testing completed:

[ ] Serum IgE level, date: _________ [ ] CBC, date: _______ [ ] Other: __________

8. **Patient Assistance & REMS Program Enrollment**

[ ] Yes, patient has been enrolled in _______________________ program. (Provide Copy Enrollment Forms)
[ ] No, patient has not been enrolled in any programs.

7. **Physician's Name**: ____ **Phone:** _________________
Physician's Signature: ____**Date:** _______________

(This drug administration order form is valid for 12 months)