Fax: 561-516-6626 | Email: Info@infuseone.com | Phone: 561-337-4055

INFUSE ONE

(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

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

every 2 weeks every 4 weeks

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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