175 Memorial Highway. Suite 1-1
New Rochelle, NY
10801

914-460-4891
fuse@fuseinfusion.com
914-460-4571

(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 IV
☐ Diphenhydramine 25mg IV
☐ Cetirizine 10mg IV
☐ ______________________ *(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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