



ADULT & CHILDREN \geq 12 YEARS
OMALIZUMAB (Xolair®)
ORDER FORM

Patient Label

Date: _____

Patient Name: _____ DOB: _____

Diagnosis: _____ Diagnosis Code: _____ Height: _____

Allergies: _____ Weight: _____

Pre-appointment Documentation:

Please fax most recent office visit note documenting the patient's diagnosis as well as a copy of the patient's demographic information along with this order form.

Pre-appointment Lab Results:

The following lab tests must be ordered, completed within 90 days of treatment, and results documented prior to *initiation* of omalizumab.

Pretreatment serum IgE Date obtained: _____ Result: _____

Treatment:

Chronic spontaneous urticaria

Omalizumab (Xolair®) 150mg **OR** 300mg subcutaneously every 4 weeks

Duration of therapy (1 year unless otherwise specified): _____

Asthma, moderate to severe allergic

Pretreatment serum IgE (units/mL)	Weight (kg)			
	30 to 60	>60 to 70	>70 to 90	>90 to 150
\geq 30 to 100	150mg every 4 weeks			300mg every 4 weeks
>100 to 200	300mg every 4 weeks			225mg every 2 weeks
>200 to 300	300mg every 4 weeks	225mg every 2 weeks		300mg every 2 weeks
>300 to 400	225mg every 2 weeks		300mg every 2 weeks	Use not recommended
>400 to 500	300mg every 2 weeks		375mg every 2 weeks	Use not recommended
>500 to 600	300mg every 2 weeks	375mg every 2 weeks	Use not recommended	
>600 to 700	375mg every 2 weeks	Use not recommended		

Omalizumab (Xolair®) _____ mg subcutaneously every _____ weeks

Duration of therapy (1 year unless otherwise specified): _____

Hypersensitivity/Anaphylaxis Medications and Extravasation Management (PRN): Follow Adult Hypersensitivity Protocol as needed per Nursing Protocol for the treatment of allergic/hypersensitivity reaction. Follow established hospital protocol for extravasation.

Physician's Name (Print): _____ Signature: _____ Date: _____

Contact Number: _____ Fax Number: _____

SINAI HOSPITAL
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410-601-9311
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