BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____
Height _____ Weight _____
Infusion Location: (state and site) _____

Xolair® (omalizumab) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Allergic asthma (ICD-10)

_____ Chronic spontaneous urticaria (ICD-10)

_____ Other: _____ (ICD-10)

☐ Provider: Check to confirm patient has received epinephrine auto-injector & has been educated on use

IgE Result/Date: _____

Nursing Orders:
-Hold treatment and notify provider if patient:

- Reports signs or symptoms of serum sickness (fever, rash, joint pain/swelling/stiffness, muscle pain, swollen lymph nodes)
- Has not received epinephrine auto-injector and education on its use

Xolair _____ mg subcutaneously. Divide doses exceeding 150 mg among multiple injection sites to limit injections to not more than 150 mg per site

Dosing:
For Asthma/Chronic Rhinosinusitis dose based on IgE levels and weight
For Chronic Spontaneous Urticaria flat dose of 150mg or 300mg

Frequency: Every _____ weeks

Observation Period:

- Following the first three injections, monitor patient for post-injection observation period of 2 hours. For all subsequent injections, monitor patient for 30 minutes
- Record vital signs prior to discharge
- If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol to include administration of epinephrine 0.3 mg IM STAT

Additional Orders:

_____

_____

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 5/3/23 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.