



St. Charles Health System

Adult Ambulatory Infusion Order
Omalizumab (XOLAIR)
including biosimilars

Patient Name:
Date of Birth:

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____ kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE _____**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Pre-treatment serum IgE level needed based on indication:
 - a. For chronic idiopathic urticaria, serum IgE level not needed.
 - b. For asthma and IgE-mediated food allergy, serum IgE level must be obtained before the first treatment with omalizumab. Dose is determined by initial IgE level and body weight. Do NOT use IgE levels for subsequent dose determinations unless treatment has been interrupted for more than 1 year. Dose should be adjusted during therapy only for significant changes in body weight.
3. Do not abruptly discontinue systemic or inhaled corticosteroids upon initiation of omalizumab therapy.
4. Patient must be given prescription for an EPINEPHrine auto-injector (EPIPEN) and instructed to bring one to each infusion appointment. If patient does not bring an EPINEPHrine auto-injector (EPIPEN), then they must stay for 2 hours of observation after administration.
5. Anaphylaxis may occur during or after the first dose or with repeat dosing. Anaphylaxis may occur upon restart of therapy following a 3-month gap. There have been reports of anaphylaxis up to 4 days after administration of omalizumab. Monitor patients closely after administration.

LABS:

IgE, serum, already drawn:

Result: _____ ku/L

Date: _____

NURSING ORDERS

1. Serum IgE level needed based on indication:
 - a. For chronic idiopathic urticarial, serum IgE level not needed.



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2. For asthma and IgE-mediated food allergy, notify provider if there is a significant change in the patient's body weight since previous dose was administered. Dose may need to be adjusted.
3. Observe patient for hypersensitivity reactions, including anaphylaxis, for 2 hours after administration of the first dose and 30 minutes after any subsequent administrations. Patient must have an EPINEPHrine auto-injector (EPIPEN) on hand. If patient does not have an EPINEPHrine auto-injector (EPIPEN), then patient must stay for 2 hours of observation.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

MEDICATIONS

1. Dose is determined by initial IgE level and body weight. Do NOT use IgE levels for subsequent dose determinations unless treatment has been interrupted for more than 1 year. Dose should be adjusted during therapy only for significant changes in body weight

Omalizumab (XOLAIR) injection, subcutaneous

Dose (must check one):

- 75 mg
- 150 mg
- 225 mg
- 300 mg
- 375 mg
- 450 mg
- 525 mg
- 600 mg

Interval (must check one):

- Every 2 weeks
- Every 4 weeks

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status



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6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed