NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-307-2244
Phone: 405-515-2470

ORD

Omalizumab (Xolair)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment:

☑ Moderate persistent asthma, uncomplicated (J45.40)

Orders

☑ Omalizumab (Xolair) _____ MG SUBCUTANEOUS EVERY _____ WEEKS (J2357 : 5 MG = 1 unit)

Doses GREATER THAN 150 MG MUST be divided and administered into more than one injection site (e.g. 225 MG or 300 MG administered as two injections, 375 MG administered as three injections). Injections may take 5 to 10 seconds to administer (solution is slightly viscous).

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES