Omalizumab
(XOLAIR)

Health Redeemer
Infusion Therapy Center

PROVIDERS: Please include the following information to expedite the order:
Patient demographics, insurance information, most recent visit notes, and applicable labs

PATIENT INFORMATION

Patient: _____ DOB: _____

ICD-10: ☐J45.0 ☐L50.0 ☐J33.0 ☐Z91.0 ☐Other: _____ Description: _____

Allergies: _____ ☐NKDA Weight: _____ ☐ lb ☐ kg

Patient Status: ☐ New to Therapy ☐ Continuation of Therapy Last Treatment Date: _____ Next Due Date: _____

REFERRAL STATUS ☐New Referral ☐Updated Order ☐Order Renewal

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

☒ Utilize hypersensitivity protocol established by Redeemer Health Infusion Therapy Center

☒ Provide nursing care and observation according to Redeemer Health Infusion Therapy Center policies and procedures

THERAPY ADMINISTRATION

☐ Omalizumab (XOLAIR)

Dose: ☐75mg ☐150mg ☐225mg ☐300mg ☐375mg ☐450mg ☐525mg ☐600mg

Route: subcutaneous injection

Frequency: ☐q 2 weeks ☐q 4 weeks

Monitoring: ☐Patient required to stay for 30-minute observation

Refills: ☐ No Refills ☐ 12 months ☐ _____

LABORATORY ORDERS

☐ CBC ☐at each dose ☐every _____

☐ CMP ☐at each dose ☐every _____

☐ CRP ☐at each dose ☐every _____

☐ Other: _____

☐ Please check this box if you do NOT authorize Redeemer Health Infusion Therapy Center to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

☐ acetaminophen (TYLENOL) ☐500 mg ☐650 mg ☐1000 mg PO

☐ cetirizine (ZYRTEC) 10 mg PO

☐ loratadine (CLARITIN) 10 mg PO

☐ diphenhydramine (BENADRYL) ☐25 mg ☐50 mg | ☐PO ☐IV

☐ methylprednisolone (SOLU-MEDROL) ☐40 mg IV ☐125 mg IV

☐ hydrocortisone (SOLU-CORTEF) 100 mg IV

SPECIAL INSTRUCTIONS

Redeemer Health Infusion Therapy Center will conduct peer-to-peer review(s) on behalf of the prescribing provider for any insurance denials. If you DO NOT AUTHORIZE Redeemer Health Infusion Therapy Center to do this on your behalf, check this box.☐

Provider Name (Print): _____ **Provider Signature (No Stamps):** _____ **Date:** _____