Atrium Health

Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401
	☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390
	☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Xolair® (Omalizumab) Injection Order (Revised 10/14/2025)

All orders with a √ will be placed.

Patient Demographics:		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list)		
☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
Asthma Related	
☐ J45.40 - Moderate persistent asthma, uncomplicated	☐ J45.50 - Severe persistent asthma, uncomplicated
☐ J45.41 - Moderate persistent asthma with (acute) exacerbation	☐ J45.51 - Severe persistent asthma with (acute) exacerbation
☐ J45.42 - Moderate persistent asthma with status ashamaticus	☐ J45.52 - Severe persistent asthma with status asthmaticus
☐ Other:	
Nasal Polyps Related	
☐ J33.0 - Polyp of nasal cavity	☐ J33.1 - Polypoid sinus degeneration
☐ J33.8 - Other polyp of sinus	☐ J33.9 - Nasal polyp, unspecified
☐ Other:	
Urticaria Related	
☐ L50.0 - Allergic urticaria	☐ L50.1 - Chronic idiopathic urticaria (CIU)
☐ L50.8 - Other specified urticaria	☐ Other:

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion:
Complete Medication List - Include all tried and failed meds	Next infusion due date:
	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:	
☑ Required Lab results: Serum total IgE PRIOR to start of treatment (**Fax with order**)	
☑ Hold Tx and Notify Provider IF: - Serum total IgE: Abnormal value or not on file	

Nursing Communication:	
☑ Obtain vital signs, to include blood pressure, heart rate, temperature, and oxygen saturation, PRE-injection and obtain heart rate and blood pressure POST-injection PRN.	
☑ Monitor patient for 2 hours AFTER the first treatment, 1 hour AFTER the second treatment, and 30 minutes for all subsequent treatments for sign and symptoms of reaction.	

Infusion Therapy:	
☑ Omalizumab (Xolair)	
☐ _____mg SC every 2 weeks	☐ _____mg SC every 4 weeks

Hypersensitivity Protocol:	
☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.	

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted	
Signature:	Date: