Atrium Health Infusion Centers
Phone: 704-468-3400 **Fax:** 704-468-3401

Xolair Injection Order (Revised 4/3/21)

Instructions to Provider: All orders with ☒ will be placed unless otherwise noted. Please fax completed order, along with referral form.

Required Lab Results: Serum total IgE level prior to start of treatment. (If outside of Atrium, please fax with order, required prior to scheduling)

Infusion Therapy:

☒ Xolair (omalizumab) _____ mg SC

Frequency: every _____ weeks

ICD 10 code: _____

Additional Orders:

_____

_____

Special Instructions:

- Follow Atrium Health Infusion Center protocol for hypersensitivity PRN.

Injection Monitoring:

- Obtain vital signs, to include a BP, HR, temperature, and O2 saturation, pre-injection and obtain HR and BP post-injection PRN.
- Monitor patient for 2 hours after the first injection, 1 hour after the second injection, and 30 minutes for all subsequent injections for signs and symptoms of reaction.

Physician Name: _____

Physician Signature: _____

Date: _____ (Order valid for 1 year)

Patient Name:

DOB:

MRN: