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| **Patient:****XOLAIR (omalizumab)****Asthma** | **DOB:**  |
| \*\*check appropriate box\*\***\*\*All orders with ☒ will be placed unless otherwise noted\*\*** |
| **Required lab results and/or tests prior to scheduling:**Ige |
| **ICD 10/Primary Diagnosis:**  | **ICD10/Secondary Diagnosis:** |
| **Height:** | **Weight:** | **Allergies:** |
| **Infusion Therapy**  | **Frequency**  |
| [x]  Xolair (omalizumab) \_\_\_\_\_\_\_\_\_ mg SQ**Frequency**: every \_\_\_\_\_\_\_\_\_\_\_\_\_ weeks | **Every** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **weeks****Number of doses**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **PRN MEDS:**N/A | **PRN EMERGENCY MEDS:**[x]  Per Facility protocol[ ]  Provider requested Emergency Medication\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Labs** |
| [ ]  **Labs drawn prior to scheduling infusion (results provided) -**  IgE**Labs to be drawn over treatment course by facility:**  [ ]  **NO LABS REQUIRED** |
| **LAB** | **FREQUENCY** | **LAB** | **FREQUENCY** |
|  |  |  |  |
|  |  |  |  |
| **Nursing Communication/Orders** |
| * 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.
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