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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:**  Ig  e | | | | | |
| **ICD 10/Primary Diagnosis:** | | | **ICD10/Secondary Diagnosis:** | | |
| **Height:** | **Weight:** | | **Allergies:** | | |
| **Infusion Therapy** | | | **Frequency** | | |
| Xolair (omalizumab) \_\_\_\_\_\_\_\_\_ mg SQ  **Frequency**: every \_\_\_\_\_\_\_\_\_\_\_\_\_ weeks | | | **Every** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **weeks**  **Number of doses**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **PRN MEDS:**  N/A | | | **PRN EMERGENCY MEDS:**  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** |
|  | |  |  | |  |
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| **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. | | | | | |