Clearwater: Phone: 727.977.9717 I Fax: 727.977.9717
Tampa: Phone: 813.775.9997 I Fax: 813.775.9997
Email: intake@sageinfusion.com I Online: www.sageinfusion.com

Xolair (omalizumab) Injection Orders

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please provide ICD10 code)

☐ NKDA Allergies:

☐ New Start Therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

HISTORY

Positive Skin or RAST test? ☐ YES or ☐ NO Test Date: _____

Pre-Treatment IgE Serum: _____ IU/ml Test Date: _____

REQUIRED LABS

☑ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (please attach)

XOLAIR ORDERS

DOSING:

☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg

FREQUENCY:

Subcutaneously every ☐ 2 weeks or ☐ Every 4 weeks

Notes: _____

REFILLS:

☐ _____
(if not indicated prescription will expire one year from date signed)

Sage Infusion Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

_____
Provider Name

_____ _____
Provider Signature Date

Anaphylaxis, presenting as bronchospasm, hypotension, syncope, urticaria, and/or angioedema of the throat or tongue, has been reported to occur after administration of Xolair.
Malignancy: Malignancies have been observed in clinical studies.
Acute Asthma Symptoms: Do not use for the treatment of acute bronchospasm or status asthmaticus.
Corticosteroid Reduction: Do not abruptly discontinue corticosteroids upon initiation of XOLAIR therapy.