



(omalizumab)

XOLAIR injection orders

Patient Name

DOB

Phone

M

F

DIAGNOSIS *Please provide ICD-10 code*

Allergic Asthma

Chronic Idiopathic Urticaria

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO

Solu-Cortef 100mg IVP

Cetirizine 10mg PO

Diphenhydramine 25mg IVP

(other)

(other)

XOLAIR ORDERS

DOSAGE				PATIENT WEIGHT	
150mg	225mg	300mg	375mg	lbs.	
FREQUENCY				kg	
every 2 weeks		every 4 weeks			
ALLERGIC ASTHMA HISTORY					
Positive RAST or Skin Test				Test Date:	
Pre-treatment Serum IgE:				Lab Date:	

NOTES

ORDERING PROVIDER

Signature X _____ Date

Provider

Phone

Fax