smartinfusion THERAPY SERVICES

Phone: 608-690-7210
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www.MySmartInfusion.com

Location

☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

Xolair (Omalizumab)
Subcutaneous Injection Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____ Allergies to Latex: ☐ Yes ☐ No

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Severe Eosinophilic Asthma ICD 10 Code: J45.50
☐ Chronic Idiopathic Urticaria ICD 10 Code: L50.1
☐ Polyp of Nasal Cavity ICD 10 Code: J33.0

Required Tests (within 12 months & attach results)

☐ Serum IgE Level
☐ Pulmonary Function Test (asthma only)
☐ Perennial Aeroallergen Test or Skin Test (asthma only)

Adverse Reaction Management & Nursing Orders

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:
- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM

☐ Other: _____

☒ Manage VAD per protocol:

☒ Start/Access and Discontinue PIV/CVC

☒ Flush with NS and/or Heparin per protocol based on line type

☒ Other: _____

Xolair Medication Order

Refill x12 months unless otherwise noted: _____

Patient Weight: _____ KG

Dosage – Subcutaneous Injection

☐ 75mg ☐ 150mg ☐ 225mg
☐ 300mg ☐ 375mg ☐ Other _____

Frequency

☐ Every 4 weeks

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____