

ADMIT to outpatient infusion service **for Omalizumab (Xolair).**

Diagnosis:

- ☐ ASTHMA
☐ CHRONIC IDIOPATHIC URTICARIA
☐ Other (specify) _____

Lab:

- ☐ Other (specify) _____

Pre-Meds:

- ☐ Other (specify) _____

For Anaphylactic Reaction:

- ☐ Give 0.3mg Epinephrine injection IM in lateral thigh x 1 dose. Repeat x 1 dose if symptoms are not improved in 5-10 minutes.

Notify Physician.

- ☐ Other (specify) _____

Infusion Orders

Drug	Fluid	Total dose	Route
Omalizumab (Xolair)	In 3 ml syringe	<input type="checkbox"/> 150 mg <input type="checkbox"/> 225 mg (given in 2 sites) <input type="checkbox"/> 300 mg (given in 2 sites) <input type="checkbox"/> 375 mg (given in 3 sites)	SubQ

Ancillary Treatment/Administrative Procedures

- ❖ May use Infusion Center standing orders.
- ❖ Doses >150 mg should be divided over more than one injection site, dose > 300 mg should be divided over 3 sites.
- ❖ Injection site should be separated by ≥ 1 inch. Do not inject into moles, scars, bruises, tender areas, or broken skin.
- ❖ Follow the regimen below to monitor for signs/symptoms of allergic reaction (itching, rash, throat tightness, shortness of breath, etc.)
 - For first injection: Monitor for signs/symptoms of allergic reaction for 2 hours post injection.
 - For second injection: Monitor for signs/symptoms of allergic reaction for 1 hour post injection.
 - For third injection: Monitor for signs/symptoms of allergic reaction for 30 minutes post injection.
 - After third injection: May leave Infusion center after injection.

Schedule repeat injection: Every _____ weeks x _____ months.

Call ordering Physician's office and notify of the next injection date scheduled.

Physician Signature _____ Date _____ Time _____

EAST ALABAMA MEDICAL CENTER
Omalizumab (Xolair)
EAMC Infusion Order Set

Patient Identification