VANCOUVER CLINIC® **ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER** Attn: Infusion department **Omalizumab (XOLAIR®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

Weight:_____lb/kg Height:_____inch/cm

Diagnostic Code ICD-10:_____ Diagnosis:_____

□ Initial Consult □ Annual Renewal

Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering.

Patients will be seen by our internal infusion clinician for purposes of providing care.

GUIDELINES FOR ORDERING:

- Send FACE SHEET and H&P, relevant labs and/or most recent chart note
- Vancouver clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- Pre-treatment serum IgE level needed based on indication:
    - For chronic idiopathic urticaria, serum IgE level not needed.
    - For asthma, serum IgE level must be obtained before the first treatment with Omalizumab. Dose is determined by initial IgE level and body weight. Do NOT use IgE levels for subsequent dose determinations unless treatment has been interrupted for more than 1 year.
- If labs are not accessible through Epic, please fax a copy of request lab as well (see below). Otherwise, authorized Vancouver Clinic infusion clinician to order the lab.
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).

LABS:

- IgE, serum, already drawn:
  Result_____ku/L, Date of collection:_____

Please fax the completed form and pertinent information to Fax: 360-604-1776

Vancouver Clinic Outpatient Infusion Service *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245

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ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER

Attn: Infusion department

Omalizumab (XOLAIR®)

NAME:
DOB:
INSURANCE:
PROVIDER NAME:
CLINIC NAME and Phone number:

MEDICATIONS:

For Chronic Idiopathic Urticaria:

- ☐ Omalizumab (XOLAIR®) injection 150 mg, subcutaneously for every 4 weeks for _____ dose(s)
- ☐ Omalizumab (XOLAIR®) injection 300 mg, subcutaneously for every 4 weeks for _____ dose(s)

- ☐ Patient transition to self administration after 3 doses, nurse please provider patient education for self administration.

For Asthma:

- ☐ Omalizumab (XOLAIR®) injection_____ mg, subcutaneously for every_____ weeks for _____ dose(s)

- ☐ Patient transition to self administration after 3 does, nurse please provider patient education for self administration.

Nasal polyps

- ☐ Omalizumab (XOLAIR®) injection_____ mg, subcutaneously for every_____ weeks for _____ dose(s)

- ☐ Patient transition to self administration after 3 does, nuse please provider patient education for self administration.

Provider's signature: _____

Provider's printed name: _____Date:_____

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