Intravene – Xolair Injection Orders (rev 10/2015)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ Zip Code _____
Home Phone # _____
Work Phone # _____
DOB _____SSN _____
Height _____ Weight _____lbs
Drug Allergies_____
□ NKDA Sex: □ Male or □ Female

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
_____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____DEA#_____
State License#_____

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DIAGNOSIS (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

Other Asthma Therapies (tried and/or failed)	**Name of Drug**	**Date Failed**
□ Short–acting Beta-agonist	_____	_____
□ Inhaled Corticosteroids (without LABA)	_____	_____
□ Long-acting Beta-agonist (without ICS)	_____	_____
□ Combination Therapy (LABA/ICS)	_____	_____
□ Oral Steroids	_____	_____
□ Other (specify)	_____	_____

LAB RESULTS:

□ History of positive skin or RAST test to a perennial aeroallergen
Pretreatment serum IgE level IU/mL (1.0 kU/L=1.0 IU/mL; 2.4 ng/mL=1.0 IU/mL)_____ Test Date:_____
FEV1 Predicted Percent_____

PRESCRIPTION:

Prescription Type: □ Naïve patient □ Restart □ Continue therapy

Prescription Dispense XOLAIR

Subcutaneously, every 4 weeks
□ 150mg/dose
□ 300 mg/dose

Subcutaneously, every 2 weeks:
□ 225 mg/dose
□ 300 mg/dose
□ 375 mg/dose

Other Dose_____ Frequency_____

Duration: □ 1 year □ 6 months □ 3 months □ other_____

Signature, prescribing MD _____ Date _____

Anaphylactic meds available at the bedside:
Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD
Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD
Diphenhydramine 50mg vial. Administer 50mg IV push upon order of MD

VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL