

**Provider Order Form rev.**

**PATIENT INFORMATION**

**Referral Status:**  New Referral  Updated Order  Order Renewal

Patient Name:	DOB:	Patient Phone:
Patient Address:	Patient Email:	
Allergies:	<input type="checkbox"/> NKDA	Weight (kg):
Sex: <input type="checkbox"/> M / <input type="checkbox"/> F	Date of Last Infusion:	Height (cm):
Insurance carrier:	Next Due Date:	PA date:
	PA #:	

**DIAGNOSIS (Please provide ICD-10 code in space provided)**

<input type="checkbox"/> Asthma:	<input type="checkbox"/> Chronic spontaneous urticaria:
<input type="checkbox"/> IgE Mediated Food Allergy:	<input type="checkbox"/> Chronic Rhinosinusitis:
<input type="checkbox"/> Other:	Description:

**DOSING (Choose one)**

For Chronic Spontaneous Urticaria:  150mg /  300mg

For Asthma / Chronic Rhinosinusitis / IgE mediated food allergy:  
\_\_\_\_\_mg (dose based on IgE levels and weight)

**FREQUENCY**

Every \_\_\_\_\_ weeks

**THERAPY ADMINISTRATION**

- Administer Xolair subcutaneously. Divide doses exceeding 150mg among multiple injection sites to limit injections to not more than 150mg per site.
- Following the first three injections, monitor the patient for post-injection observation period of 2 hours. For all subsequent injections, monitor patient for 30 minutes.

**LABORATORY ORDERS**

Other: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

Other: \_\_\_\_\_

**NURSING**

- Hold infusion and notify provider for reports signs or symptoms of serum sickness (fever, rash, joint pain/swelling/stiffness, muscle pain, swollen lymph nodes)
- Confirm patient has epinephrine auto-injector if required and understands indications for use.
- Provide nursing care and post- procedure observation per policy
- In the event of an infusion reaction, per RRMC Infusion Reaction Management policy, the patient may receive:
  - Acetaminophen 1000 mg orally
  - Epinephrine 0.5 mg IM
  - Diphenhydramine 25-50 mg IV push
  - Normal saline IV at 150 mL/hr
  - Methylprednisolone 125 mg IV push

**PROVIDER INFORMATION**

Preferred Contact Name:	Preferred Contact Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

**REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)**

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, & number of flares per year  
**Required Labs:** Skin test, IgE

**Provider Name (print)**

**Provider Signature**

**Time**

**Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

Form # 5510 created 8/2025



White- Patient  
Yellow- Medical Records

