ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

OMALIZUMAB (XOLAIR)

Patient Name: _____ Date of Birth: _____

Patient Phone Number: _____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE (REQUIRED):

- ❑ Allergic Asthma (moderate to severe) (ICD-10: _____)
- ❑ Chronic spontaneous/idiopathic urticaria (ICD-10: _____)
- ❑ Nasal polyps (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

REQUIRED: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

OMALIZUMAB SUBCUTANEOUS INJECTION
Pre-filled syringe is preferred unless the patient has a documented allergy to latex

Dose _____ mg

❑ Every 2 Weeks

❑ Every 4 Weeks

❑ Every _____ Weeks

LENGTH OF THERAPY: ❑ 1 Year (Maximum/Default) ❑ 6 months ❑ Other: _____

ADDITIONAL INFORMATION/MONITORING: _____

SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after injection when vital signs are stable, and no reaction is present. If no injection-related events with previous 3 doses, may waive post-monitoring period and discharge home after completion.

Provider Signature: _____ Date: _____

Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

OMALIZUMAB (XOLAIR)

MultiCare

Yakima Memorial Hospital