Troy Infusion Center
600 W Main Street
Suite 120
Troy, OH 45373
Phone: 937-401-6620
Fax: 937-401-6629

Washington Township Infusion Center
1989 Miamisburg-Centerville Road
Suite 101
Dayton, OH, 45459
Phone: 937-401-6620
Fax: 937-401-6629

Xolair® (omalizumab) Order Form

Epic Referral: REF115227

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____

ICD-10 Diagnosis:

☐ Asthma (J45.0) ☐ Chronic Spontaneous Urticaria (L50.1) ☐ Nasal Polyps (J33.9) ☐ Other _____

Xolair subcutaneous injection

- Patient must bring epi-pen with them, please ensure an Rx was sent for a patient to obtain an epi-pen from an outpatient pharmacy
- Patients will be observed for 2 hours after their first 3 injections and 30 minutes after subsequent injections to ensure there is no anaphylactic or serious injection reaction
- Prefilled syringes must sit out for 15 minutes prior to administration

Dose:

☐ Xolair 150 mg ☐ Xolair 225 mg ☐ Xolair 300 mg ☐ Xolair 375 mg ☐ Xolair _____mg

Frequency:

☐ Every 2 weeks ☐ Every 4 weeks ☐ Other _____

Duration:

☐ 6 months ☐ 1 year ☐ Other _____

Other Orders/Comments: _____

Prescriber Printed Name:_____

Prescriber Full Address: _____

Office Phone Number: _____ **Office Fax Number:** _____

Prescriber Signature: _____ **Date:** _____