KVH Klickitat Valley Health

Outpatient Omalizumab (Xolair) Order Set

Phone: 509-772-2695 Fax: 509-773-3354

General

Patient Name ___________________ DOB ___________ Height _____ Weight ______ Phone #___________

Order Start Date _______________________________ Order Expiration Date _________________________

Allergies: ____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. 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. Dose should be adjusted during therapy only for significant changes in body weight.
3. Do not abruptly discontinue systemic or inhaled corticosteroids upon initiation of omalizumab therapy.
4. Patient must be given prescription for an EPINEPHrine auto-injector (EPIPEN) and instructed to bring one to each injection appointment. If patient does not bring an EPINEPHrine auto-injector (EPIPEN), then they must stay for 2 hours of observation after administration.
5. Anaphylaxis may occur during or after the first dose or with repeat dosing. Anaphylaxis may occur upon restart of therapy following a 3-month gap. There have been reports of anaphylaxis up to 4 days after administration of omalizumab. Monitor patients closely after administration.

PRE-SCREENING *(Results must be available prior to initiation of therapy)*:

☐ IgE serum test results scanned with order

DIAGNOSIS CODE: ****IF using 'Other' must include ICD10 code****

☐ J.45 Asthma ☐ Other: _________________________

Nursing Orders

☒ Notify provider if there is a significant change in the patient's body weight since previous dose was administered. Dose may need to be adjusted.

☒ Observe patient for hypersensitivity reactions, including anaphylaxis, for 2 hours after administration of the first dose and 30 minutes after any subsequent administrations. Patient must have an EPINEPHrine auto-injector (EPIPEN) on hand. If patient does not have an EPINEPHrine auto-injector (EPIPEN), then patient must stay for 2 hours of observation

☒ Vital Signs: baseline and every 30 minutes until discharge.

Medication Orders

☐ Omalizumab (Xolair) _____ mg subcutaneously every _____ weeks for _____ total doses.

IF ANAPHYLACTIC REACTION OCCURS

☒ Stop infusion immediately, notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Patient Name:
DOB:

Phone: 509-772-2695 Fax: 509-773-3354

Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patent identified on this form.

I hold an active, unrestricted license to practice medicine in ____________ *(specify state)*

My physician license number is # _________________ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: ________________________________ **Date** ______________

Printed name: ______________________ **Phone:** _____________ **Fax:** _____________

KVH Provider Co-signature:

**Required for all external orders*

Provider Signature: ________________________________ **Date** ______________

Printed name: ______________________

Patient Name:

DOB: