Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax: 231-727-4328

Omalizumab (Xolair®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ____/____/____ **Site of Service:** ☐ TH Muskegon ☐ TH Shelby

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ **Date of Birth**: ____/____/____ **Weight:** _____kg **Height:** _____cm **Allergies:** _____	**Primary Insurance:** _____ **Member ID:** _____ **Secondary Insurance:** _____ **Member ID:** _____
Diagnosis Diagnosis Code (ICD-10): _____ Indication: _____ Target start date: _____	**Labs** ☐ Baseline serum total IgE ☐ Other: _____

Pre-medications: No pre-medications are routinely given. Pre-medications may be ordered at physician discretion.
☐ Other:_____

Note to provider: Dose based on pretreatment serum IgE and patient weight

℞ Omalizumab (Xolair®) Subcutaneous Injection

Dosing: ☐150mg ☐225mg ☐300mg ☐375mg ☐ Other: _____
Frequency: ☐ Every 2 Weeks ☐ Every 4 weeks ☐ Other: _____

Nursing orders:
Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____
Office Phone Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner)
Note: This order is valid for 12 months from date of physician signature.

Provider Signature: _____
Office Fax Number: _____