Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

Physician’s Orders
OMALIZUMAB - PEDIATRIC, OUTPATIENT, INFUSION CENTER
Page 1 of 2

Defaults for orders not otherwise specified below:
☐ Interval: Every 28 days
☐ Interval: Every ____ days

Duration:
☐ Until date: __________
☐ 1 year
☐ ______# of Treatments

Anticipated Infusion Date __________ ICD 10 Code with Description __________________________________________________________________________________________

Height _______(cm) Weight _______(kg) Allergies ________________________________________________________________________________________

Provider Specialty
☐ Allergy/Immunology  ☐ Infectious Disease  ☐ OB/GYN  ☐ Rheumatology
☐ Cardiology  ☐ Internal Med/Family Practice  ☐ Other  ☐ Surgery
☐ Gastroenterology  ☐ Nephrology  ☐ Otolaryngology  ☐ Urology
☐ Genetics  ☐ Neurology  ☐ Pulmonary  ☐ Wound Care

Site of Service
☐ SH Gerber  ☐ SH Lemmen Holton (GR)  ☐ SH Pennock  ☐ SH United Memorial
☐ SH Helen DeVos (GR)  ☐ SH Ludington  ☐ SH Reed City  ☐ SH Zeeland

Appointment Requests
☐ Infusion Appointment Request
Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Infusion

Provider Reminder
☐ ONC PROVIDER REMINDER
For symptoms of allergic reaction or anaphalaxis, order "Peds Hypersensitivity Reactions" Therapy Plan.

Provider Ordering Guidelines
☐ ONC PROVIDER REMINDER 26
Dose of omalizumab is based on pretreatment IgE level and body weight. Dose should be adjusted for significant changes in body weight. If therapy has been interrupted for greater than or equal to 1 year, total IgE level should be re-evaluated for dosing determination.

Lab Orders
☐ __________________________________________________________________________  ☐ Every ____ days  ☐ Until date: __________
☐ Once  ☐ 1 year
☐ ______# of Treatments

Pre-Medications
☐ Pre-medication with dose: __________________________________________________________________________

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.
Medications

☑ omalizumab (XOLAIR) subcutaneous injection solution
  Subcutaneous, Once, Starting S, For 1 Doses
  Dose:
  □ 150 mg
  □ 300 mg
  Doses greater than 150 mg are divided among more than one injection site to limit injections to less than 150 mg per site.

Nursing Orders

☑ ONC NURSING COMMUNICATION 70
  Due to viscosity, injections may take 5 to 10 seconds to administer.

☑ ONC NURSING COMMUNICATION 72
  - Notify attending physician, NP or PA-C if patient has itching, hives, swelling, fever, rigors, dyspnea, cough or bronchospasm. Notify if greater than 20% decrease in systolic or diastolic blood pressure.
  - Verify that patient has diphenhydramine / Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.
  - Observe patient in the infusion center for 2 hours following completion of injection.