ADULT AMBULATORY INFUSION ORDER
Omalizumab (XOLAIR) Injection

Weight: _________ kg   Height: _________ cm

Allergies: ___________________________________________________________

Diagnosis Code: _____________________________________________________

Treatment Start Date: _________   Patient to follow up with provider on date: _________

**This plan will expire after 365 days at which time a new order will need to be placed**

GUIDELINES FOR ORDERING
1. Send FACE SHEET and H&P or most recent chart note.
2. Pre-treatment serum IgE level needed based on indication:
   a. For chronic idiopathic urticaria, serum IgE level not needed.
   b. For asthma, 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 infusion 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.

LABS:

- □ IgE, serum, already drawn:
  - o Result _________ ku/L
  - o Date _________

NURSING ORDERS:
1. Serum IgE level needed based on indication:
   a. For chronic idiopathic urticaria, serum IgE level not needed.
   b. For asthma diagnosis, please indicate result of IgE serum level.
       Level: _________ ku/L on (date) _________
   
2. For asthma, 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.
3. 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.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
### MEDICATIONS:

#### For Asthma:

<table>
<thead>
<tr>
<th>Pretreatment serum IgE</th>
<th>Patient Weight 30-60 kg</th>
<th>Patient Weight 61-70 kg</th>
<th>Patient Weight 71-90 kg</th>
<th>Patient Weight 91-150 kg</th>
<th>Patient Weight Over 150 kg</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-100 ku/L</td>
<td>150 mg every 4 weeks</td>
<td></td>
<td></td>
<td>300 mg every 4 weeks</td>
<td>Consult pharmacist</td>
</tr>
<tr>
<td>101-200 ku/L</td>
<td>300 mg every 4 weeks</td>
<td></td>
<td></td>
<td>225 mg every 2 weeks</td>
<td>Consult pharmacist</td>
</tr>
<tr>
<td>201-300 ku/L</td>
<td>300 mg every 4 weeks</td>
<td>225 mg every 2 weeks</td>
<td></td>
<td>300 mg every 2 weeks</td>
<td>Consult pharmacist</td>
</tr>
<tr>
<td>301-400 ku/L</td>
<td>225 mg every 2 weeks</td>
<td>300 mg every 2 weeks</td>
<td>Insufficient data to recommend a dose</td>
<td>Insufficient data to recommend a dose</td>
<td></td>
</tr>
<tr>
<td>401-500 ku/L</td>
<td>300 mg every 2 weeks</td>
<td>375 mg every 2 weeks</td>
<td>Insufficient data to recommend a dose</td>
<td>Insufficient data to recommend a dose</td>
<td></td>
</tr>
<tr>
<td>501-600 ku/L</td>
<td>300 mg every 2 weeks</td>
<td>375 mg every 2 weeks</td>
<td>Insufficient data to recommend a dose</td>
<td>Insufficient data to recommend a dose</td>
<td></td>
</tr>
<tr>
<td>601-700 ku/L</td>
<td>375 mg every 2 weeks</td>
<td>Insufficient data to recommend a dose</td>
<td>Insufficient data to recommend a dose</td>
<td>Insufficient data to recommend a dose</td>
<td></td>
</tr>
</tbody>
</table>

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.

**Omalizumab (XOLAIR) injection, subcutaneous**

**Dose (must check one)**

- [ ] 150 mg
- [ ] 225 mg
- [ ] 300 mg
- [ ] 375 mg

**Interval (must check one)**

- [ ] Every 2 weeks
- [ ] Every 4 weeks
For Chronic Idiopathic Urticaria:

Omalizumab (XOLAIR) injection, subcutaneous
Dose (must check one)
☐ 150 mg
☐ 300 mg

Interval (must check one)
• Every 4 weeks

Doses greater than 150 mg will be divided for injection at separate sites. Use a 25 gauge needle for subcutaneous injection. Administration may take 5-10 seconds due to product viscosity.

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. Diphenhydramine (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
3. Famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
4. Hydrocortisone sodium succinate (SOLUCORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction
5. Epinephrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity reaction

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ ______________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license Number is # ______________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); 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/Time: ______________________
Printed Name: ______________________ Phone: ______________________ Fax: ______________________
OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

☐ Beaverton
   OHSU Knight Cancer Institute
   15700 SW Greystone Court
   Beaverton, OR 97006
   Phone number: 971-262-9000
   Fax number: 503-346-8058

☐ NW Portland
   Legacy Good Samaritan campus
   Medical Office Building 3, Suite 150
   1130 NW 22nd Ave.
   Portland, OR 97210
   Phone number: 971-262-9600
   Fax number: 503-346-8058

☐ Gresham
   Legacy Mount Hood campus
   Medical Office Building 3, Suite 140
   24988 SE Stark
   Gresham, OR 97030
   Phone number: 971-262-9500
   Fax number: 503-346-8058

☐ Tualatin
   Legacy Meridian Park campus
   Medical Office Building 2, Suite 140
   19260 SW 65th Ave.
   Tualatin, OR 97062
   Phone number: 971-262-9700
   Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders