Omalizumab (XOLAIR) Injection

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

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:
- Result _____ ku/L
- Date _____

NURSING ORDERS:

1. Serum IgE level needed based on indication:
    a. For chronic idiopathic urticarial, 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

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MEDICATIONS:

For Asthma:

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

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

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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 (OHSU HC-PAT-133-GUD, HMC C-132). 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 or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion 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**: _____

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Central Intake:

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