

## XOLAIR INJECTION REFERRAL FORM

### PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:	
DATE OF REFERRAL:	ADDRESS:	
DATE OF BIRTH:	CITY, STATE, ZIP:	
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:		
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE	MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST	NKDA

### PRIMARY DIAGNOSIS:

J33.0 - Polyp of the nasal cavity	J33.1 - Polypoid sinus degeneration	J33.8 - Other polyp of sinus
J33.9 - Nasal polyp, unspecified	J45.40 - Moderate persistent asthma, uncomplicated	J45.50 - Severe persistent asthma, uncomplicated
L50.0 - Allergic Urticaria	L50.1 - Idiopathic urticaria	L50.8 - Other (chronic, recurrent) urticaria
		L50.9 - Unspecified urticaria
Other		

### REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

1. INSURANCE CARD (Front & Back)
  2. PATIENT DEMOGRAPHICS
  3. MOST RECENT LABS
  4. MEDICATION LIST  
 5. H & P
  6. RESULTS OF POSITIVE SKIN TEST OR IN VITRO REACTIVITY TO A PERENNIAL AEROALLERGEN

### PRIMARY MEDICATION ORDER:

### PRN & PREMEDICATIONS:

PRIMARY MEDICATION ORDER:			MEDICATIONS	30 minutes prior to every injection	PRN
Xolair Subcutaneous Injection 75 mg                      150 mg                      225 mg 300 mg                      375 mg                      450 mg 525 mg                      600 mg					
Frequency every 2 weeks                      every 4 weeks			Acetaminophen 650 mg PO		PRN every ___ hour for mild or moderate injection reaction.
Other:			Diphenhydramine 25 mg PO		PRN every ___ hour for mild or moderate injection reaction.
FIRST DOSE:      Y              N			Diphenhydramine 25 mg IV		PRN every ___ hour for mild or moderate injection reaction.
<input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.			Methylprednisolone 125 mg IV		PRN every ___ hour for mild or moderate injection reaction.
			Other: _____		PRN every ___ hour for mild or moderate injection reaction.

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

- ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)  
 START PIV/ACCESS CVC (As Needed for ADVERSE REACTIONS)  
 OTHER: (please fax other reaction orders if checking this box)

### PRESCRIBER INFORMATION: Please check preferred form of communication.

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	EMAIL:
CITY, STATE, ZIP:	NPI:

 (GENERIC SUBSTITUTION PERMITTED)  
 PHYSICIAN SIGNATURE:

DATE:

 (DISPENSE AS WRITTEN)  
 PHYSICIAN SIGNATURE:

DATE:

# XOLAIR INJECTION REFERRAL FORM

## FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

*\*This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INJECTION REACTION	MODERATE INJECTION REACTION	SEVERE INJECTION REACTION/ANAPHYLAXIS
<b>SYMPTOM CLASSIFICATION</b>	<ul style="list-style-type: none"> <li>Flushing</li> <li>Dizziness</li> <li>Headache</li> <li>Apprehension</li> <li>Diaphoresis</li> <li>Palpitations</li> <li>Nausea / Vomiting</li> <li>Pruitis</li> </ul>	<ul style="list-style-type: none"> <li>Chest Tightness</li> <li>Shortness of Breath</li> <li>Hypo/hypertension (&gt;20 mmHg Change in Systolic BP from Baseline)</li> <li>Increased Temperature (&gt;2 Degrees Fahrenheit)</li> <li>Urticaria</li> </ul>	<ul style="list-style-type: none"> <li>Hypo/hypertension (&gt;40 mmHg Change in Systolic BP from Baseline).</li> <li>Increase Temperature (&gt;2 Degrees Fahrenheit) with Rigors</li> <li>Shortness of Breath with Wheezing</li> <li>Laryngeal Edema</li> <li>Chest Pain</li> <li>Hypoxemia</li> </ul>
<b>TREATMENT PROTOCOL FOR ADULTS &gt;66LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
<b>TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

**FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

## FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
<b>ADULT &gt; 66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
<b>PEDIATRIC 33 LBS - 66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

**FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

\*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.