Prestige Infusions
116 Boonton Avenue
Kinnelon NJ 07405
Phone : 973-850-6843
Fax : 973-860-4530
www.prestigeinfusion.com

Affiliation: ApexHealthRX METRODRUGS RX OAKHILLSPRX SPECIALTY PHARMACY GoldenHealthCare Specialty Pharmacy

XOLAIR
(omalizumab)

Patient Name DOB

Phone M F

DIAGNOSIS *Please provide ICD-10 code*

Allergic Asthma

Chronic Idiopathic Urticaria

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

(other)

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

(other)

XOLAIR ORDERS

DOSAGE

150mg 225mg 300mg 375mg

PATIENT WEIGHT

lbs.

kg

FREQUENCY

every 2 weeks every 4 weeks

ALLERGIC ASTHMA HISTORY:

Positive RAST or Skin Test Test Date:

Pre-treatment Serum IgE: Lab Date:

NOTES

ORDERING PROVIDER

Signature **X** ______________________________ Date

Provider Phone Fax