BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

OMALIZUMAB ORDERS

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (406) 752-0443

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last injection:

DIAGNOSIS

☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ **Signed order** ☐ **Demographics and insurance info** ☐ **H&P, labs, tests, progress notes supporting dx**

• Prior Therapies:	☐ Serum IgE level (Asthma/rhinositis dx):
☐ Pulmonary Function Tests (Asthma Dx)	☐ Perennial aeroallergen test or skin test result (Asthma Dx)

PRESCRIBING INFORMATION

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐ **Omalizumab** ☐ **Specific Product (optional):**	75mg/0.5mL OR 150mg/mL OR 300mg/2mL	**Dose:** ☐ 75mg ☐ 150mg ☐ 225mg ☐ 300mg ☐ 375mg ☐ 450mg ☐ 525mg ☐ 600mg **Frequency:** ☐ Every 2 weeks ☐ Every 4 weeks Inject subcutaneously	☒ # PFS for dose Refills:

If no product is specified, an insurance-preferred biosimilar may be used.
If not specified, order will be valid for 1 year from the date of signature.

OBSERVATION

Observe the patient for at least 2 hours after the first 3 injections, then 30 minutes thereafter

Other Observation Order: ☐

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/5mLHeparin 100u/mL(Port)final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60 min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain $SpO_2$95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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