vitalcare® of the FOUR STATES

IMMUNOGLOBULIN ORDER FORM

Vital Care of the Four States, 109 E Hickory St., Neosho, MO 64850
OFFICE 417-451-7900 / FAX 417-451-7915

DEMOGRAPHICS

Patient Name: _____

Address: _____

City: _____ State: ____ Zip:_____

DOB: ____/____/____ ☐ Male ☐ Female

Phone: _____

SSN: _____ Ht: _____ Wt: _____

PRESCRIBING PHYSICIAN

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Fax: _____

License#: _____

DEA#: _____NPI: _____

ALLERGIES / REACTIONS

_____

_____

Signature: _____

Date: _____

PHYSICIAN ORDERS

☐ **XOLAIR (omalixzumab)** **REFILLS: _____**

Prescription type: ____ Naive/New start ____ Restart ____ Last injection Date: _____

MG/DOSE - 2 WEEKS

____ 150 mg ____ 225 mg ____ 300 mg ____ 375 mg ____ 450 mg ____ 525 mg ____ 600 mg

MG/DOSE - 4 WEEKS

____ 75 mg ____ 150 mg ____ 225 mg ____ 300 mg ____ 450 mg ____ 600 mg

☐ **PRE-MEDICATIONS** **REFILLS: _____**

- ☐ Diphenhydramine 25 MG PO or IV (circle) 30 -60 minutes before infusion
- ☐ Solu-Medrol _____ MG IV – 30 minutes before infusion
- ☐ OTHER: _____
- ☐ OTHER: _____

☐ **Anaphylaxis Kit per Pharmacy protocol**

TO BE ADMINISTERED BY THE HEALTH CARE PROVIDER **PRN** FOR PATIENTS RECEIVING IV MEDS IN THE HOME

Epinephrine Auto Injector 0.3mg/0.3ml IM – Repeat one time in 20 minutes if needed

DIAGNOSIS:

☐ _____ ☐ _____