Cinqair

Provider Order Form

PATIENT INFORMATION

Patient Name: DOB:

Patient Home Phone: Patient Cell Phone: Patient Email:

Emergency/Alternate Contact Name: Emergency/Alternate Contact Phone:

◯ NKDA ◯ Allergies: Weight lbs/kg: Height:

Patient Status: ◯ New to Therapy ◯ Continuing Therapy ◯ Therapy Change Last infusion date (if applicable):

REQUIRED DOCUMENTATION

◯ Labs ◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

ICD-10 CODE

◯ J45.50 Severe eosinophilic asthma ◯ Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) ◯ 500mg ◯ 650mg ◯ 1000mg PO

Cetirizine (Zyrtec) ◯ 10mg PO

Loratadine (Claritin) ◯ 10mg PO

Diphenhydramine (Benadryl) ◯ 25mg ◯ 50mg ◯ PO ◯ IV

Methylprednisolone (Solu-Medrol) ◯ 40mg IV ◯ 125mg IV

Hydrocortisone (Solu-Cortef) ◯ 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Cinqair (reslizumab) **Dose** ◯ 3mg/kg IV ◯ round up to nearest whole vial ◯ give exact dose **Frequency** ◯ every 4 weeks

PROVIDER INFORMATION

Provider Name: Provider Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

SPECIAL INSTRUCTIONS

Provider Name **Provider Signature** **Date** ◯ **Check here if this is a stat order**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.