CINQAIR® (reslizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

____ ______________________

Patient Name **DOB**

______ ______ ______________________________ ________________

Height **Weight** **Allergies** **Patient Phone**

Medical History
Patient over 18 years of age? ☐ Yes ☐ No
Asthma Symptoms controlled by corticosteroids? ☐ Yes ☐ No
Blood Eosinophil level of at least 400cells/mcl ☐ Yes ☐ No Level __________

Diagnosis (must include ICD-10 code)
☐ Severe Asthma ______________ ☐ Asthma with acute exacerbation______________
☐ Other (ICD-10 Code):___________________ Date Diagnosed_________________

<u>Prescription Orders: CINQAIR® (reslizumab) 100mg/10ml</u> vial

Sig: Infuse 3mg/kg IV over 60 minutes every 4 weeks.
Monitor patient for one hour after first two infusions.

Anaphylaxis Protocol Orders: ☐ EpiPen 0.3mg Dispense #2 (Refills______)
****Patients must carry EpiPen at all times.**

Refills: ☐12 months ☐__________infusions

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Physician Name **Phone** **Fax**

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Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com

Updated 06/23/2010