Phone and Fax: 608-690-7210
www.MySmartInfusion.com

Cinqair (Reslizumab)

Infusion Order Form

Patient Information

Patient Name: _____DOB: _____ M ☐ F ☐

Allergies: _____

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

☐ Severe Eosinophilic Asthma ICD 10 Code: J45.50

Required Tests (within 12 months & attach results)

-Blood Eosinophils

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, Including reaction management and post-procedure observation.

Special Instructions / Notes

Cinqair Medication Order

Patient Weight: _____ KG

Dosage

☐ 3mg/kg
☐ Other _____

Frequency

☐ Every 4 weeks
☐ Other _____

Required Documents

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

Location

☐ Eau Claire ☐ Weston ☐ Middleton

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____