smartinfusion THERAPY SERVICES

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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

☐ Other: _____ ICD 10 Code: _____

Required Tests (within 12 months & attach results)

Pulmonary Function Test Result _____

Blood Eosinophils Result _____

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 and Progress Notes

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____