

Cinqair (Reslizumab) Infusion Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code): _____

Other: _____

NKDA Allergies: _____

New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- Acetaminophen _____ mg by PO
- Cetirizine _____ mg by PO
- Diphenhydramine _____ mg by PO/ IVP
- Solu-Medrol _____ mg by PO/ IVP
- Solu-Cortef _____ mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Other: _____

Patient Height and Weight:

Patient Height (cm): _____ Patient Weight (kg): _____

Cinqair Medication Order:

- IV Infusion
- Dosing (Please choose one):
 - 3 mg/kg
 - Other: _____
- Frequency (Please choose one):
 - Every 4 weeks for 12 months
 - Other: _____

<p>Additional Instructions/Notes:</p> 	<p>Patient IV Access</p> <ul style="list-style-type: none"> <input type="checkbox"/> PIV <input type="checkbox"/> Use patient's SL/DL PICC, flush per protocol <input type="checkbox"/> Access/deaccess patient's Port, flush per protocol <p><small>*Imaging results of proper placement required for PICC/Port</small></p>
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Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400