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# 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: _____

**Additional Instructions/Notes:**

**Patient IV Access**

□ PIV
□ Use patient's SL/DL PICC, flush per protocol
□ Access/deaccess patient's Port, flush per protocol
*Imaging results of proper placement required for PICC/Port

**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
□ *Orland Park, IL*: 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400