Cinqair Order Form
(reslizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code

☐ J45.50 Severe Persistent Asthma, Uncomplicated
☐ J45.51 Severe Persistent Asthma, w/ Acute Exacerbation
☐ J45.52 Severe Persistent Asthma, w/ Status Asthmaticus
Other: _____

Prescribing Information

The patient may not be eligible to receive Cinqair if they have signs, symptoms, or are being treated for a parasitic infection or if they are having acute bronchospasm and/or an asthma attack.

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Blood Eosinophil Level (Pre-treatment baseline count ≥ to 400 cells/mcL) (Absolute Eosinophil in K/mcL x1000 = cells/mcL)**

PRESCRIPTION

Cinqair (reslizumab)

Dose:

IV: Infuse 3 mg/kg in 50-100 mL of 0.9% Sodium Chloride over at least
30 minutes via pump with a 0.2-micron filter every 4 weeks for one year

Patient Weight: _____ lbs **or** _____ kg

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____