medix infusion

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 elibible 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)

Loading 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

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

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

Comments:

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PRESCRIBER INFORMATION

Prescriber Name: ____________ Signature: ____________

Date: ________ NPI #: ____________ Specialty: ____________

Supervising Physician: ____________ (If Applicable)

Address: ____________ City: ____________ State: ________ Zip: ________

Contact Name: ____________ Phone: ____________ Fax: ____________ Email: ____________