medix infusion

Cinqair Order Form
(reslizumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ______________________________

DOB: ______________ Phone: ______________ Sex: M F

DIAGNOSIS & CLINICAL INFORMATION

Primary ICD 10 Code (Required)

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

Weight: __________ lb kg Height: __________

Patient Status:

New to therapy
Continuing therapy (date of last dose ______________)

Allergies: ______________________________

PRESCRIPTION

CINQAIR (reslizumab)

IV: Infuse 3 mg/kg every 4 weeks for one year.

Is the patient on any other disease modifying therapy? **Yes** **No**

Is yes, please note therapy and last dose: ______________________________

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

Other Orders:

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REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:
Blood Eosinophil Level (pre-treatment baseline count ≥ to 400 cells/mcL). Absolute Eosinophil in K/mcL x 1000 = cells/mcL

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

Signature: ______________________________

NPI #: ______________________________ Date: ______________

Supervising Physician (if applicable): ______________________________

Address: ______________________________

City: ______________________ State: ______________ Zip: ______________

Contact Name: ______________________ Phone: ______________ Fax: ______________