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: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

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

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

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:

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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