

CINQAIR

Please include the following to expedite the order:

Patient Demographics, Insurance Information, Labs

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

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

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ J45.50 (Severe Persistent Asthma) ☐ J45.51 (Severe Persistent Asthma with acute exacerbation)

☐ J45.52 (Severe Persistent Asthma with status asthmaticus) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐ kg ☐ lbs **Height:** _____ ☐ cm ☐ in

TREATMENT

CINQAIR (reslizumab)

Route: Intravenous infusion

Dose: ☐ 3 mg/kg

Frequency:

☐ Once every 4 weeks

☐ Other: _____

Quantity: _____ **Refills:** _____

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity protocol established by Cure Stat Infusion Services.

Special Instructions: _____

Provider Signature: _____

Date: _____