

# Cinqair IV Order

(Reslizumab)



Ph: 805-719-3700 | Fax: 805-852-2636

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Treatment Location: \_\_\_\_\_

**\*Please fax a copy of the following patient information:**

- Demographics     Insurance Information     Current Lab Results  
 H & P Relevant to the Diagnosis     Current Medications

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs / kg    Height: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-10: \_\_\_\_\_

## PROVIDER INFORMATION

Printed Provider's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

## CINQAIR DOSAGE

3 mg/kg every 4 weeks     Other: \_\_\_\_\_ Total dose: \_\_\_\_\_ mg

Start Date of Infusion: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Blood eosinophil level must be  $\geq$  400 cells/mcL within 6 months of dosing.  
Monitor patient for 30 minutes post-infusion.**