Cinqair

INFUSION FOR HEALTH

InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: ____________ Treatment Location: ____________

PROVIDERS: Please include the following to expedite the order.

Demographics, Insurance Information, Current CBC & CMP,
H&P Relevant to the Diagnosis, Current Medications

PATIENT INFORMATION

Patient Name: ____________

Patient Contact Number: ____________

DOB: ____________

Allergies: ____________

Weight: ________ lbs / kg Height: ________

Diagnosis: ☐ J82.83

Other Dx/ICD10: ____________

PRESCRIBER INFORMATION

Prescriber's Name: ____________

Signature: ____________

NPI: ________ Date: ________

Phone: ________ Fax: ________

Office Address: ____________

Contact Person: ____________

Contact Email: ____________

PREMEDS

☐ No Premeds

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

CINQAIR DOSAGE

Date of Last Treatment, if Continuation: ____________ Route: ☑ IV

☐ 3 mg/kg every 4 weeks ☐ Other: ____________ Total Dose: ________ mg

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

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.