

CINQAIR (reslizumab) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

☐ _____ Severe Eosinophilic Asthma

☐ _____
(other)

Pre-Medication:

- ☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Cetirizine 10mg PO ☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

- ☒ Patient Demographic Sheet
☒ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☒ Blood Eosinophil result & date *(please attach)*

CINQAIR ORDERS:

Dose/Frequency:

☐ 3mg/kg IV every 4 weeks ☐ Other: _____

Pt. weight: _____
(ensure unit of measure is noted)

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

- ☒ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____