(reslizumab)

CINQAIR infusion orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ __________ Severe Allergic Asthma with Eosinophilic Phenotype
- ☐ __________ ______________________________ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ ______________________________ *(other)*
- ☐ Length of Need ______________
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________________ *(other)*

CINQAIR ORDERS

DOSAGE

3mg/kg IV every 4 weeks

PATIENT WEIGHT

________lbs.

________kg

Refills: ______________

Notes

____

ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________

Address ____

____

NPI# ______________________

DEA# ______________________

FAX ORDERS: 702-780-4887