Cinqair
(reslizumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Severe persistent asthma, uncomplicated (J45.50)
☐ Severe persistent asthma with (acute) exacerbation (J45.51)
☐ Severe persistent asthma with status asthmaticus (J45.52)
☐ Pulmonary eosinophilia, not elsewhere classified (J82.00)
☐ Other: _____

PRESCRIPTION

☐ Cinqair 3mg/kg IV every 4 weeks x 1 year

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Tried/Failed Therapies
- FEV1 Score
- Eosinophil count

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this medication.
☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.