NORTH TEXAS INFUSION CENTERS

CINQAIR® (reslizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)

_____ _____
Patient Name **DOB**

_____ _____ _____ _____
Height **Weight** **Allergies** **Patient Phone**

Medical History
Patient over 18 years of age? ☐Yes ☐No
Asthma Symptoms controlled by corticosteroids? ☐Yes ☐No
Blood Eosinophil level of at least 400cells/mcl ☐ Yes ☐ No Level _____

Diagnosis (must include ICD-10 code)
☐Severe Asthma _____ ☐Asthma with acute exacerbation_____
☐Other (ICD-10 Code):_____ Date Diagnosed_____

<u>Prescription Orders: CINQAIR® (reslizumab) 100mg/10ml</u> vial
0.2 micron filter must be used during infusion
Sig: Infuse 3mg/kg IV over 30-60 minutes every 4 weeks.
Monitor patient for 1 hour after first 2 infusions and 30 min. for the following infusions.

Anaphylaxis Protocol Orders: ☐EpiPen 0.3mg Dispense #2 (Refills_____)
****Patients must carry EpiPen at all times.**

Refills: ☐12 months or for ☐_____infusions

_____
Provider Name **Phone** **Fax**

_____
Provider's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com