





MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: 1-800-809-1265 Fax: 1-866-872-8920

### Guidelines for Prescribing CINQAIR® (reslizumab)

(Required documentation with all initial referrals)

Patient Name: \_\_\_\_\_

Referral Date: \_\_\_\_\_

\_\_\_\_ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-5)  
(Infusion order forms & Standard Adverse Reactions orders are available at [www.palmettoinfusion.com](http://www.palmettoinfusion.com) under Agency/MD tab)

\_\_\_\_ Include patient demographic information and insurance information. (Copy of insurance cards if available)

\_\_\_\_ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any documented use of inhaled or oral corticosteroids, glucocorticoids, theophylline, leukotriene modifiers, short or long acting beta-agonists. Any lab results and/or Pulmonary Function Tests to support diagnosis.**

- CINQAIR® is an interleukin-5 antagonist monoclonal antibody (IgG4 kappa) indicated for add-on maintenance treatment of patients with severe asthma aged 18 years and older, and with an eosinophilic phenotype.

\_\_\_\_ If patient is switching biologic therapies such as Xolair® or Nucala®, then MD must specify wash-out period prior to starting CINQAIR® as specified of \_\_\_\_\_ weeks.  
Last known therapy: \_\_\_\_\_ and last known date received: \_\_\_\_\_.

\_\_\_\_ Other as requested: \_\_\_\_\_  
\_\_\_\_\_

**Pre-Screening:**

\_\_\_\_ **Blood Eosinophil Level** (Pre-treatment baseline count greater than or equal to 400 cells/mcL)  
(Absolute Eosinophil in K/ $\mu$ L x 1000 = cells/mcL)

**\*\* Warnings/Precautions: Anaphylaxis reactions:** These events were observed during or within 20 minutes after completion of the CINQAIR® infusion and reported as early as the second dose of CINQAIR. Manifestations included dyspnea, decreased oxygen saturation, wheezing, vomiting, and skin and mucosal involvement, including urticaria. **Acute Asthma Symptoms:** Do not use for the treatment of acute bronchospasm or status asthmaticus. **Malignancy:** have been observed in clinical studies. **Corticosteroid Reduction:** Do not abruptly discontinue corticosteroids upon initiation of therapy. **Helminth Infections:** Treat patients with pre-existing parasitic infections before therapy. If patients become infected while receiving treatment and do not respond to anti-helminth treatment, then discontinue Xolair® until parasitic infection resolves. **Pregnancy/Breastfeeding:** Discuss Pregnancy or breastfeeding plans/risks prior to start of therapy. See full prescribing information.

**Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.**

**Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.**