MRN:_____

DOB:_____

STANDARD CINQAIR® (reslizumab) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive CINQAIR® (reslizumab) if patient has signs/symptoms of parasitic infection, is currently being treated for a parasitic infection, or is having acute bronchospasm and/or asthma attack.

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1. Patient Name:_____ Height (inches):____ Weight (lbs):____

2. Allergies: _____

3. Diagnosis:

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation

☐ J45.52 Severe persistent asthma with status asthmaticus

☐ Other **ICD-10 Code/description:** _____

Dose/Frequency:

CINQAIR® (reslizumab) 3 mg/kg per 50-100 ml Sodium Chloride 0.9% IV to infuse over at least 30 minutes via pump with 0.22-micron filter every 4 weeks; followed each infusion with a 30-minute post observation period.

Special orders: _____

_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

4. Physician's Signature:_____/_____ Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing CINQAIR® (reslizumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ 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/µL 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.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.