

Cinqair® (reslizumab) Standard Plan of Treatment

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight:	LB or KG	Gender: Allergies: See list NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/>	J45.50 - Severe persistent asthma, uncomplicated
<input type="checkbox"/>	J45.52 - Severe persistent asthma with status asthmaticus
<input type="checkbox"/>	J45.51 - Severe persistent asthma with (acute) exacerbation
<input type="checkbox"/>	- Other: _____

REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	IF ORDER CHANGE:
5	Baseline serum eosinophil level	THERAPY:	
6			
			Continue current order until insurance approved

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Prescribing information does not suggest pre-medication.

IV	Diphenhydramine	25mg	50mg	PO	Acetaminophen	325mg	500mg	650mg	1000mg	
	Methylprednisolone	40mg	125mg		Other:	Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

MEDICATION/DOSE:

Cinqair® (reslizumab) 3mg/kg per 50-100mL NS IV to infuse over at least 30 minutes.

SPECIAL/LAB ORDERS:

FREQUENCY:


Dosing every 4 weeks

Other: _____

Each infusion followed with a 1-hour post observation period.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC <input checked="" type="checkbox"/> Flush device per facility standard flushing procedure	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.	
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PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

_____	_____
Dispense as written/Brand medically necessary	Substitution permitted