

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

Cinqair® (reslizumab) Standard Plan of Treatment

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	
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.	
---	---	---

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



Palmetto

INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- 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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com