Referral Status:			MRN:
☐ New referral	☐ Order change	☐ 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)

- ☐ J45.50 - Severe persistent asthma, uncomplicated
- ☐ J45.52 - Severe persistent asthma with status asthmaticus
- ☐ J45.51 - Severe persistent asthma with (acute) exacerbation
- ☐ ________- Other:____

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Baseline serum eosinophil level
6	

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **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		
☐ Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:	
☐ Famotidine	☐ 20mg	☐ 40 mg		
☐ Other:				

PO				
☐ Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
☐ Famotidine	☐ 20mg	☐ 40mg		
☐ Diphenhydramine	☐ 25mg	☐ 50mg		
☐ 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:

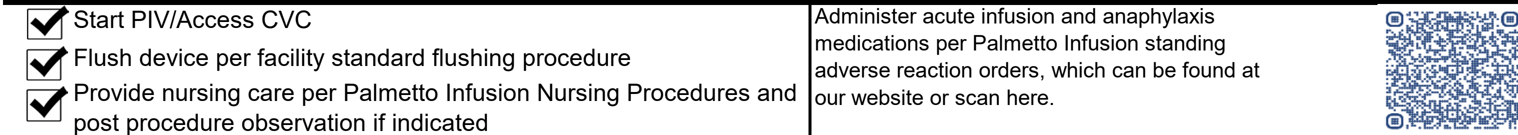
☐ ____
____

FREQUENCY:

☐ Dosing every 4 weeks
☐ Other: ____

Each infusion followed with a 30 minute post observation period.

☑ Refills x 12 months unless noted otherwise here:



NURSING ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure
- ☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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	

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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com