

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	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg	PO	Acetaminophen	<input type="checkbox"/> 325mg	<input type="checkbox"/> 500mg	<input type="checkbox"/> 650mg	<input type="checkbox"/> 1000mg	
	Methylprednisolone	<input type="checkbox"/> 40mg	<input type="checkbox"/> 125mg		Other:	Famotidine	<input type="checkbox"/> 20mg	<input type="checkbox"/> 40mg		
	Famotidine	<input type="checkbox"/> 20mg	<input type="checkbox"/> 40 mg			Diphenhydramine	<input type="checkbox"/> 25mg	<input type="checkbox"/> 50mg		
	Other:					Fexofenadine	<input type="checkbox"/> 60mg	<input type="checkbox"/> 180mg		
					Cetirizine	<input type="checkbox"/> 10mg				
					Loratadine	<input type="checkbox"/> 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