Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

| Referral Status: | | MRN: |
|---|---|---|
| ☐ New referral | ☐ Order change | ☐ Order Renewal |
| Patient preferred clinic: | | |

# Cinqair® (reslizumab) Standard Plan of Treatment

Rev 4.28.25

## PATIENT DEMOGRAPHICS:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Patient Name: | | | | | | | |
| Patient's Phone: | | 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: | | PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE? | |
|---|---|---|---|
| 1 | Insurance information | IF NO: | IF YES: |
| 2 | Most recent History & Physical | PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| 3 | Full medication list | | NEXT INFUSION DATE: |
| 4 | Tried and failed therapies | | **IF ORDER CHANGE:** |
| 5 | Baseline serum eosinophil level | | ☐ **Continue current order until insurance approved** |
| 6 | | | |

## 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.

**FREQUENCY:**

- ☐ Dosing every 4 weeks
- ☐ Other: _____

**SPECIAL/LAB ORDERS:**

☐ _____

_____

**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.

## 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 | |