

## INFUSION ORDERS- CINQAIR (RESLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

\*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Severe Eosinophilic Asthma      ICD 10 Code: J45.5 Does your patient have a blood eosinophil count of 400 cells/ $\mu$ L or greater? <input type="checkbox"/> YES <input type="checkbox"/> NO

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Lung Function Test Results	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis, including blood eosinophils
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Cinqair 3mg/kg IV every 4 weeks** <input type="checkbox"/> Cinqair _____ IV every 4 weeks
Patient's Most Recent Weight = _____ kg	
Refills: <input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses	

\*\* Patient weight is required for all weight-based orders.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

**All information contained in this order form is strictly confidential and will become part of the patient's medical record. Contact us with questions at: (877) 448-3627 Fax Completed Form and all documentation to: 866-507-1164**