

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



Reslizumab (Cinqair) Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION
<input type="checkbox"/> Reslizumab (Cinqair) in 50ml 0.9% sodium chloride intravenous infusion over 25-50 minutes <ul style="list-style-type: none">Dose: <input type="checkbox"/> 3mg/kg<ul style="list-style-type: none"><input type="checkbox"/> round up to nearest whole vial<input type="checkbox"/> give exact dose <input type="checkbox"/> Other _____Route intravenousFrequency: <input type="checkbox"/> every 4 weeks <input type="checkbox"/> Other _____
<input type="checkbox"/> Flush with 0.9% sodium chloride at the completion of infusion
<input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion/injection
<input type="checkbox"/> Patient is NOT required to stay for observation time
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months/ _____ (if not indicated order will expire one year from date signed) Total doses _____ Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____