*Westerville*
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

*Lancaster*
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

# Reslizumab (Cinqair)
## Provider Order Form

***Date:*** _____

| PATIENT INFORMATION | | |
|---|---|---|
| Name: | DOB: | SEX: M ☐ F ☐ |
| ICD-10 code (required): | ICD-10 description: | |
| ☐NKDA Allergies: | | Weight lbs/kg: |

**REFERRAL STATUS**

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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**

☐ **Reslizumab** (Cinqair) in 50ml 0.9% sodium chlorideintravenous infusion over 25-50 minutes
- Dose:☐ 3mg/kg
  ☐ round up to nearest whole vial
  ☐ give exact dose ☐ Other_____
- Route intravenous
- Frequency: ☐ every 4 weeks ☐ Other_____

☐ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion/injection

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ 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 _____