Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION

Mission Medical

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

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 _____