

# Reslizumab (Cinqair)

Provider Order Form rev. 10/12/2022



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## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- Provide nursing care per 360 Infusion Center Nursing Procedures, including reaction management and post-procedure observation

## SPECIAL INSTRUCTIONS

## THERAPY ADMINISTRATION

- Reslizumab** (Cinqair) in 50ml 0.9% sodium chloride intravenous infusion over 25-50 minutes
  - Dose:  3mg/kg
  - round up to nearest whole vial
  - give exact dose
  - Route: intravenous
  - Frequency:  every 4 weeks
- Flush with 0.9% sodium chloride at infusion completion
- Patient is required to stay for 30-minute observation
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

\_\_\_\_\_  
Provider Name  
(Print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date