InfuseAble Care
INFUSION SUITES & IMMEDIATE CARE SERVICES

Patient Name
DOB
Address
Cell Phone

CINQAIR (reslizumab)

Status	☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change
Diagnosis	☐ ICD 10 Code: J45.___ Severe persistent asthma ☐ ICD 10 Code: J82 Primary eosinophilia ☐ ICD 10 Code: _____ Other: _____
Pertinent Medical History	Patient's weight (most recent): _____ lbs / kg (circle one) Date: _____ **Initial** Requests: Eosinophil count: _____ Date: _____ **Renewal** Requests: Did the patient experience measurable evidence of improvement in disease activity and/or severity? (Provide documentation) ☐ Y ☐ N
Labs	Labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician If Infusion Clinic: _____
Medication Order	☐ Cinqair 3mg/kg IV every 4 weeks Dose will be rounded up to nearest 100mg - ***OR*** - ☐ Give exact dose Refills: ☐ x 1 year ☐ x _____doses ☐ No refills; give this dose only.
Monitoring	Monitor for signs/symptoms of hypersensitivity during injection and 30 mins post-injection. For any signs of infusion reaction: Contact on-site provider for instruction.
Additional Orders	
Physician Information	Physician Name _____ NPI _____ Office Contact _____ Phone _____ **Provider Signature:** _____ Date _____

REQUIRED DOCUMENTATION

o	Patient Demographics & **Insurance** Information:	- Copy of patient's insurance card – front and back
o	**Clinical / Progress Notes**, supporting primary diagnosis:	- 2 most recent office notes (including documentation of number of exacerbations in past 12 months) - Medication history
o	Most Recent **Labs**:	- Labs showing elevated eosinophil count of 400 cell/uL or higher - FEV1 test results

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