Infusion Associates
Phone: 616-954-0600 Fax: 616-954-1675

Cinqair IV Infusion ORDER

(reslizumab)

***Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

DX CODES: ***ICD-10*** : _____, _____, _____

Cinqair (*reslizumab*) Intravenous Dosage:

☐ **3 mg/kg**

☐ **Other: _____**

Frequency: ☐ **Every 4 weeks** ☐ **Other:**_____

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____