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

Cinqair IV Infusion

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

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

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

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

ICD-10 : _____, _____, _____

Does the patient currently use tobacco products? ☐ Yes ☐ No

What is the patient's peripheral blood eosinophil count? _____ cells/mcL; Date drawn: _____

Has the patient had 3 or more asthma exacerbations in the past year? ☐ No ☐ Yes please select all that apply:

☐ Oral steroids were required for at least 3 days
☐ Exacerbation resulted in an ED visit and/or hospitalization

Has patient been compliant on high dose ICS/LABA inhaler for at least 3 months? ☐ Yes ☐ No

Will patient be using cinqair in combination with another biologic? ☐ Yes ☐ No

In the past 6 months, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

Cinqair (reslizumab) **IV**
3 mg/kg
☐ Other: _____

Frequency: ☐ Every 4 weeks ☐ Other:_____

Rx Expiration Date: _____/_____/_____

Printed Provider Name: _____

Provider Signature: _____

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