Phone: (833) 394-0600 Fax: (833) 996-4888

# 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

## Frequency: Every 4 weeks

**Date of last infusion if not at IA:**____________________ **Expiration Date:** _____/_____/_____

**Printed Provider Name**: _____________________________________________________________

**Provider Signature**: _________________________________________________________________

**Office Phone Number:** _____________________**Office Fax Number:** ____________________________

**Contact Name:** ______________________**Contact Phone Number:** ____________________________

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