

Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076



Reslizumab (Cinqair) Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

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 ☐ Other _____ - Route intravenous - Frequency: ☐ every 4 weeks ☐ Other _____
	☐ Flush with 0.9% sodium chloride at the completion of infusion
	☐ Patient is required to stay for 30-minute observation post infusion/injection
	☐ Patient is NOT required to stay for observation time
	☐ Refills: ☐ Zero / ☐ for 12 months/ _____ (if not indicated order will expire one year from date signed) Total doses _____ Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____