

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873



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
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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 _____