

☐ **Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ **Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225

☐ **Manhattan**
57W 57Street
Suite 601
New York, NY 10019

☐ **Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ **Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ **Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523



☐ **Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021

☐ **Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ **Manhattan**
225 East 70th Street
New York, NY 10021

☐ **Holbrook/ Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ **Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ **5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559

☐ **Long Beach**
917 Beech Street
Long Beach, NY 11561

☐ **Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901

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 _____