CINQUAIR INFUSION ORDER (reslizumab)

INFUSIONMED | USA

LIVING YOUR BEST LIFE. ONE DROP AT A TIME.

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight _____ lbs / kg

Allergies: _____

Diagnosis: _____ ICD-10: _____

TB Test Date: _____/____/____ Result: _____ Hep B Test Date: _____/____/____ Result: _____

Labs to be drawn by: O Infusion Clinic O Referring Physician

Lab Orders: _____

CINQUAIR ORDERS

Dose: O 3 mg/kg every FOUR weeks Total Dose: _____mg

Infusion Start Date: _____/_____/_____

Blood eosinophil level must be >400 cells/mcL within SIX months of dosing.

Monitor patients for THIRTY minuts post infusion.

PROVIDER INFORMATION

Provider's Name: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE SEND COPY (FRONT AND BACK) OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994