

Cinqair (reslizumab)

Provider Order Form rev. 5/20/2022



www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
	Next Due Date (if applicable):		

PROVIDER INFORMATION

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

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

J45.50 Severe eosinophilic asthma
Other: _____

MEDICATION ORDER

Cinqair (reslizumab)
Dose:
3mg/kg IV
round up to nearest whole vial
give exact dose
Frequency:
every 4 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg 650mg 1000mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25mg 50mg / PO IV
methylprednisolone (Solu-Medrol) 40mgIV 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: _____

Dose: _____ Route: _____ Frequency: _____

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order