CINQAIR (RESLIZUMAB)
INFUSION ORDERS

REQUIRED INFORMATION

- ☐ This order form signed by provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress notes, labs, tests supporting primary diagnosis
- ☐ **Required Labs:** Baseline CBC with diff with eosinophil count 400 or greater within 4 weeks

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis

- ☐ Severe Allergic Asthma with eosinophilic phenotype (ICD-10: _____)
- ☐ Other (ICD-10: _____)

J code: J2786

Cinqair: Initial dose: 3 mg/kg IV every 4 weeks

Additional instructions:

Physician Name:	Phone:	Fax:

Physician signature:	Date: