vitalcare® INFUSION SERVICES of SIOUX FALLS

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# CINQAIR (RESLIZUMAB)
# INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)
☐ **Required Labs:** Baseline CBC with differential with eosinophil count 4OO or greater within 4 weeks.

| | |
|---|---|
| **Patient Name:** | **DOB:** |
| **Allergies:** | **Patient Phone:** |

**Diagnosis:**

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

☐ Other:_____ (ICD-10: _____)

**J Code: J2786**

## CINQAIR ORDERS

Pt. Weight _____ kg

**Cinqair:** ☐ Initial Dose: 3mg/kg IV every 4 weeks

**Additional Instructions:**

| | | |
|---|---|---|
| **Physician Name:** | **Phone:** | **Fax:** |
| ****Physician Signature:** | **Date:** | |