Cinqair®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

ATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Severe persistent asthma, uncomplicated, J45.50

☐ Severe persistent asthma, with (acute) exacerbation, J45.51

☐ Severe persistent asthma, with status asthmaticus, J45.52

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Cinqair® (reslizumab)	_____ mg (3 mg/kg)	Infuse IV over 20-50 minutes every 4 weeks x 1 year ☐ Observe patient for 30 minutes after each dose

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI: _____ Specialty: _____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

☐ Pre-treatment serum eosinophil count

☐ Pre-treatment pulmonary function test

- ☐ FEV-1 <80% predicted
- ☐ FEV-1 reversibility ≥12% and 200mL after albuterol administration

☐ Other: _____

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____