

**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 400 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

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

Pt. Weight _____ kg

Additional Instructions:

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