vitalcare® of CENTRAL MISSISSIPPI

Fountains Infusion Center

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Phone: 601.859.8200 Fax: 601.859.8201

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:**	