(reslizumab)

CINQAIR infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Severe Allergic Asthma with Eosiniphilic Phenotype

☐ _____ _____
(other)

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____
(other)

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____
(other)

CINQAIR ORDERS

DOSAGE

◉ 3mg/kg IV every 4 weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____