MIC | METRO INFUSION CENTER

INFUSION ORDERS- CINQAIR (RESLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
☐ Severe Eosinophilic Asthma ICD 10 Code: J45.5
Does your patient have a blood eosinophil count of 400 cells/µL or greater? ☐ YES ☐ NO

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ Lung Function Test Results	☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis, including blood eosinophils
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Dosing	☐ Cinqair 3mg/kg IV every 4 weeks** ☐ Cinqair _____ IV every 4 weeks
Patient's Most Recent Weight = _____ kg	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

** Patient weight is required for all weight-based orders.

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627

Fax completed form and all documentation to (866) 507-1164

All information contained in this form is strictly confidential and will become part of the patient's medical record.