Cinqair (reslizumab)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
www.aleracare.com
ph: 888-209-8874 fax: 833-329-4738

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ J45.50 Severe eosinophilic asthma

☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg / ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mgIV ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Cinqair (reslizumab)

Dose:

☐ 3mg/kg IV

- ☐ round up to nearest whole vial
- ☐ give exact dose

Frequency:

☐ every 4 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**