

CINQAIR infusion orders

Patient Name

DOB

Phone

M

F

DIAGNOSIS Please provide ICD-10 code

Severe Allergic Asthma with Eosinophilic Phenotype

(other)

PRE-MEDICATION

Tylenol 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

(other)

(other)

CINQAIR ORDERS

DOSAGE

3mg/kg IV every 4 weeks

PATIENT WEIGHT

lbs.

kg

NOTES

ORDERING PROVIDER

Provider NPI: _____ Phone _____ Fax _____

Provider Name _____

Provider Address _____

Signature _____ Date _____