CINQAIR

Orders

RESLIZUMAB

Email: intake@infuseoneohio.com
Fax: (614) 929-7199
Phone: (614) 929-3349

Locations: ☐ Dublin, OH ☐ Lancaster, OH

INFUSE ONE OHIO

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____ **Gender** ☐ M ☐ F

Patient Address / City / State / ZIP _____ **Phone** _____

DIAGNOSIS

PLEASE PROVIDE ICD-10 CODE

☐ Severe Allergic Asthma with Eosinophilic Phenotype **ICD-10 Code** _____

☐ Other **Diagnosis / ICD-10 Code** _____

PRE-MEDICATIONS

CHECK ALL THAT APPLY

☐ Tylenol 1000 mg PO

☐ Diphenhydramine 25 mg PO

☐ Cetirizine 10 mg PO

☐ Other _____

☐ Solu-Medrol 125 mg IVP

☐ Solu-Cortef 100 mg IVP

☐ Diphenhydramine 25 mg IVP

☐ Other _____

CINQAIR ORDERS

DOSAGE

☐ 3 mg/kg IV every 4 weeks

PATIENT WEIGHT

Pounds _____ **Kilograms** _____

NOTES

ORDERING PROVIDER

Provider NPI _____ **Phone** _____ **Fax** _____

Provider Name _____

Provider Address _____

Prescriber Signature _____ **Date** _____