

(reslizumab)

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

Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO

Solu-Cortef 100mg IVP

Cetirizine 10mg PO

Diphenhydramine 25mg IVP

(other)

(other)

CINQAIR ORDERS

DOSAGE	PATIENT WEIGHT
3mg/kg IV every 4 weeks	lbs.
	kg

NOTES

ORDERING PROVIDER

Signature X Date _____

Provider _____

Phone _____

Fax _____