

Cinqair® (reslizumab) Referral Form



Patient Preferred Clinic (select one):

INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:	Patient Email:		
<input type="checkbox"/> NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per VIVO protocols.

CINQAIR THERAPY ADMINISTRATION

LABORATORY ORDERS

CBC	At each dose	Every _____
CMP	At each dose	Every _____
CRP	At each dose	Every _____
OTHER		

3mg/kg IV every 4 weeks

REQUIRED DOCUMENTATION

PREMEDICATIONS

acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg / 50mg PO / IV
 methylprednisolone (Solu-Medrol) 40mg / 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
Dose: _____ Route: _____
Frequency: _____

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Absolute Eosinophil Count(> 300 within 12 months or > 150 within 6 weeks)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)

Provider Signature

Date

Fax Numbers	Nevada: 702-489-5744	Massachusetts: 203-724-4838	Have a Question? (720) 902-4111 Email Referrals To: referrals@vivoinfusion.com
Colorado: 303-418-4679	New Jersey: 609-955-3711	Pennsylvania: 215-399-9244	
Florida: 904-930-4211	Ohio: 216-400-0674	New York: 203-724-4838	
Texas: 469-340-0044	Oklahoma: 918-770-4421	Connecticut: 203-724-4838	

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