

CINQAIR (Reslizumab) ORDER FORM

REFERRAL TYPE

New Referral
 Order Renewal
 Restart
 Frequency Change
 Dosage Change

PREFERRED LOCATION

<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 71 Thomas Johnson Drive Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006
	<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 Fairfax, VA 22031	

PATIENT INFORMATION

Name:	DOB:	Email:
Address:	Weight: KG LBS	Phone:

REFERRING PHYSICIAN INFORMATION

Name:	NPI:	
Office Contact Name:	Phone:	Fax:
Address:		

CINQAIR ORDER

OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.

Dosing/Frequency:

3mg/kg IV once every 4 weeks

Diagnosis:

- J45.50—Severe persistent asthma, uncomplicated
- J45.51—Severe persistent asthma with (acute) exacerbation
- J45.52—Severe persistent asthma with status asthmaticus

Other Diagnosis: _____ ICD-10 Code (Required): _____

Special Instructions:

Physicians Signature: _____ Date: _____ *(Order is Valid for One Year)*

REQUIRED DOCUMENTATION

Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent labs that include values for:
 - EOS within the last 3 months or prior to starting prednisone for new starts OR EOS before starting the drug for continuation of therapy
 - If available radioallergosorbent test (RAST) results
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.