Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com

(reslizumab)

INFUSE ONE

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
☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

CINQAIR ORDERS

DOSAGE

☑ 3mg/kg IV every 4 weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____