CURBSIDE INFUSION SERVICES

Fax To: (877) 428-1627
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Office: (877) 428-7248
Scheduling@curbsideinfusion.com Ext. 0
Billing@curbsideinfusion.com Ext 1

CINQAIR (reslizumab) 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 _____