

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
Quzyttir 10mg IVSP over 1-2 min

Solu-Medrol 125mg IVP
Solu-Cortef 100mg IVP
Diphenhydramine 25mg IVP

(other)

CINQAIR ORDERS

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

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____