Provider Order Form

CINQAIR (RESLIZUMAB)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Severe Asthma with an Eosinophilic Phenotype J82.5 ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Cinqair (Reslizumab), IV in 50ml 0.9% sodium chloride	☐ 3 mg/kg	☐ Every 4 weeks

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Infuse over 20-50 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

Provider Signature _____ Date _____