



CINQAIR (RESLIZUMAB) INFUSION ORDERS

PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

Diagnosis: Severe Allergic Asthma with eosinophilic phenotype (ICD-10 Code: _____)

Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs.

Allergies: _____

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

CINQAIR ORDERS

Cinqair Initial Dose: 3mg/kg IV every 4 weeks

Required Labs: Baseline CBC with differential with eosinophil count 400 or greater within 4 weeks.

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATION

<input type="checkbox"/> Arlington P: 817.200.2530 F: 817.509.0011	<input type="checkbox"/> Austin P: 512.261.4800 F: 512.261.4803	<input type="checkbox"/> Dallas P: 972.408.2777 F: 469.913.6894	<input type="checkbox"/> Houston P: 713.860.1755 F: 713.277.7219	<input type="checkbox"/> Knoxville P: 865-299-7525 F: 865-338-5604	<input type="checkbox"/> North Hills P: 817.284.2700 F: 817.284.2701	<input type="checkbox"/> Plano P: 469-974-0565 F: 469-608-2072	<input type="checkbox"/> Round Rock P: 737-443-5230 F: 737-402-7698	<input type="checkbox"/> San Antonio P: 210.366.4358 F: 210.366.4896	<input type="checkbox"/> Stone Oak P: 210.485.3700 F: 210.390.1738
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