INTRAMED Plus
infusion services

CINQAIR®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Severe persistent asthma, uncomplicated — ICD-10 Code: J45.50
_____ Severe persistent asthma w/(acute) exacerbation — ICD-10 Code: J45.51
_____ Severe persistent asthma w/status asthmaticus — ICD-10 Code: J45.52
_____ Other:_____ — ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes, labs, test supporting primary diagnosis
- Recent Lab or Test Results including documentation of elevated eosinophil levels and FEV1 test results
- Medication List
  - Including current medications treating severe asthma (oral and/or inhaled)
  - If patient is switching from another biologic, please indicate a washout period of _____weeks from last known therapy _____previously administer on _____
- Documentation of any previously trialed or failed therapies

Patient Weight: _____ lbs.
Height: _____ in.

CINQAIR® (reslizumab) J Code: J2786

4. Drug Order:

Administer 3 mg/kg (_____ mg) IV over 25-50 minutes once every 4 weeks
_____# Refills (ecommend 11 Refills

Pre-Medication Orders: Acetaminophen 650 mg PO and Diphenhydramine 25 mg PO
Administered 30 min prior to infusion *Adjust to patient's needs

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name with Credentials:_____ NPI: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**