(reslizumab)

# CINQAIR infusion orders

Evansville Multi-Specialty Clinic

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

## DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Severe Allergic Asthma with Eosiniphilic 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 _____

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