



Infusion Associates
 3230 Eagle Park NE, Suite 101
 Grand Rapids, MI 49525
 Phone: 616-954-0600 Fax: 616-954-1675

Cinqair IV Infusion ORDER
 (reslizumab)

**Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications*

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Patient Weight: _____ lbs / kg Height: _____

Diagnosis: _____

DX CODES: ICD-10 : _____, _____, _____

Cinqair (*reslizumab*) Intravenous Dosage:

3 mg/kg

Other: _____

Frequency: Every 4 weeks Other: _____

Rx Expiration Date: ____/____/____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____ Office Fax Number: _____