Allergy, Asthma & Immunology Center, P.C.
Infusion Services
www.aaicenter.net
Iftikhar Hussain, MD

**Fax Referrals To: (855) 891-2191**
**Have a Question? (855) 478-1528**

# CINQAIR® (RESLIZUMAB) ORDER FORM

*(* - Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

____ **New Referral** ____ **Order Renewal** ____ **Medication/Order Change**
____ **Benefits Verification Only** ____ **Discontinuation Order**

## Locations:

-------**Oklahoma**-------
____ Tulsa

| PATIENT INFORMATION | | | |
|---|---|---|---|
| NAME*: | | DOB*: | SEX: ☐ M ☐ F |
| ADDRESS: | | PHONE: | |
| WEIGHT: ☐ LBS ☐ KG | HEIGHT: | EMAIL: | |
| ALLERGIES: | | | |

| PHYSICIAN INFORMATION | | |
|---|---|---|
| PHYSICIAN NAME*: | | PRACTICE NAME: |
| ADDRESS: | | OFFICE CONTACT*: |
| PHONE: | FAX: | EMAIL *(FOR UPDATES)*: |

## CINQAIR ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

**ICD-10*:** _____

____ Dosing: 3mg/kg IV every 4 weeks

**Physician Signature*** _____ **Date*(Order is Valid for One Year)** _____
*Infusion will be administered per policy and protocols*

## REQUIRED DIAGNOSIS:

____ Severe Asthma
____ Eosinophilic Asthma
____ Other_____

***STAT REASON:**
**(STAT requests will be assessed per MPP policy and protocols)**

## REQUIRED DOCUMENTATION CHECKLIST:

____ Patient Demographics
____ Insurance Card/Information
____ Clinical/Progress Notes supporting DX
____ Current Medication List and H&P
____ Absolute Eosinophil Count (> 300 in prior 12mos or > 150 in prior 6 weeks)

**Last Infusion/Injection Date:** _____

**STANDING LAB ORDERS:** ____ CMP ____ CBC

____ Labs to be drawn by Infusion Center Frequency _____

***NOTES/ADDITIONAL COMMENTS:***

REVISION DATE- 5/2020