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 (Recommend 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 FAX **803.999.1754**	<u>INFUSION CENTER LOCATIONS</u> COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

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