reslizumab)	
CINQAIR	infusion orders

Please refer to website www.infuseone.com for location specific fax numbers

Patient Name

(

Phone

**DIAGNOSIS** Please provide ICD-10 code

Tylenol 1000mg PO

Cetirizine 10mg PO

Diphenhydramine 25mg PO

Email: intake@infuseone.com | Phone: 1-800-581-0645 |

Severe Allergic Asthma with Eosinophilic Phenotype

(other)

Solu-Medrol 125mg IVP Solu-Cortef 100mg IVP Diphenhydramine 25mg IVP

(other)

**CINQAIR ORDERS** 

**PRE-MEDICATION** 

DOSAGE 3mg/kg IV every 4 weeks

**NOTES** 

## **ORDERING PROVIDER**

Signature X

Provider

Phone

Fax

Date



F

(other)

**PATIENT WEIGHT** 

lbs.

kg

DOB

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