



Patient Name:
 DOB:
 Date of Last Infusion
 Insurance:

Clinic Location:
 Merrimack, NH
 Concord, NH

Cinqair® (reslizumab) Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Severe Persistent Asthma
 (ICD-10)

_____ Other: _____
 (ICD-10)

Provider: Is patient required to carry epinephrine auto-injector?

- Yes, patient has been provided epinephrine auto-injector and has been educated on its use.
- No, patient does not require epinephrine auto-injector.

Nursing Orders:

- Hold Cinqair and notify provider if patient reports:
 - Abnormal vital signs
 - current parasitic infection
 - new or worsening asthma symptoms since initiating Cinqair
- Observation period required; see below.
- If indicated by provider above, confirm patient has epinephrine auto-injector and understands indications for use.

CINQAIR 3mg/kg x current weight (_____ kg)= _____ mg in 50 mL
 0.9% sodium chloride, infuse over 20-50 minutes.
 Use in-line, sterile, non-pyrogenic low-protein binding filter (pore size 0.22 micron or less).

Frequency: Every 4 weeks (recommended) Every _____ weeks

Observation Period:

- Monitor patient for post-infusion observation period of 1 hour.
- Record vital signs pre-infusion, post-infusion and prior to discharge.
- If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol

Frequency:

Every _____ weeks

Additional Orders:

Provider name (print): _____ Date: _____

Provider signature: _____ Time: _____