Novella Infusion

Patient Name: _____
DOB: ___/___/_____
Date of Last Infusion: ___/___/_____
Height_____ **Weight**_____

Clinic Location:
☐ **Concord** ☐ **Derry**
☐ **Merrimack** ☐ **Portsmouth**

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.

Administer **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).

Observation Period:

- ☑ Monitor patient for post-infusion observation period of 60 minutes
  - ☐ Patient is required to stay for observation period following every infusion.
  - ☐ Patient may sign Release of Responsibility Form after _____ infusions.
- ☑ 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 4 weeks (recommended) ☐ Every _____ weeks

Additional Orders:

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____

Reviewed 6/16/21. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.