



**reslizumab (Cinqair®) Order Form**

**FAX to 1 (888) 797-4008**

**PATIENT INFORMATION**

Patient Name:		DOB:
Address:		
City:	State:	Zip code:
Patient's phone number:		
Is patient a Wayne Health patient registered in athena? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Order date:	Weight:    kg    lbs	Height:    m    in
Drug allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> YES. Please specify.		
ICD-10 diagnosis:		

**LABORATORY DATA**

CBC:	BMP/CMP:	Serology:
Other:		

**reslizumab (Cinqair®)**

<input type="checkbox"/> 3 mg/kg q 4 wks	<input type="checkbox"/> Other:	Refills:
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**ORDERING PHYSICIAN INFORMATION**

Name:	NPI:
Address:	
Phone number:	Fax number:
Physician signature:	Date:

*To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.*