



AYSAs

THERAPEUTICS INFUSION CENTER

CINQAIR (RESLIZUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

Demographics attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: Severe Asthma with Eosinophilic phenotype (ICD-10 Code: _____)

Other: _____ (ICD-10 Code: _____)

Patient Weight: _____ lbs.

Allergies: _____

Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

CINQAIR ORDERS

Cinqair Initial Dose: 3mg/kg IV every 4 weeks

Required Labs: Baseline CBC with differential with eosinophil count 400 or greater within 4 weeks

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____

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