175 Memorial Highway. Suite 1-1
New Rochelle, NY
10801

914-460-4891
fuse@fuseinfusion.com
914-460-4571

(reslizumab)

CINQAIR infusion orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ __________ Severe Allergic Asthma with Eosinophilic Phenotype
- ☐ __________ ______________________________ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg IV
- ☐ Diphenhydramine 25mg IV
- ☐ Cetirizine 10mg IV
- ☐ ______________________________ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________________ *(other)*

CINQAIR ORDERS

DOSAGE

⦿ 3mg/kg IV every 4 weeks

PATIENT WEIGHT

________ lbs.

________ kg

NOTES

____

ORDERING PROVIDER

Signature X ______________________________ Date ____________

Provider ______________________ Phone ____________ Fax ____________

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