

# Reslizumab (Cinqair) Order Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: Home \_\_\_\_\_ Cell \_\_\_\_\_

Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Cinqair Prior Treatment Requirements:**

- Fax H&P or progress notes that are within the last 3 months describing diagnosis and clinical status and faxed order.
- Prior authorization will be completed by a Financial Counselor after we have received the order
- Medication(s) to include dose, route, stop date and fax any required lab work

**Order:**

**Cinqair 100 mg/10 ml vial**

- Cinqair infuse 3 mg/kg IVPB every 4 weeks in 50 ml of sterile 0.9% sodium chloride USP for injection over 20-50 minutes with  0.9% NS 250 mL at KVO during infusion

Infuse \_\_\_\_\_ every 4 weeks for \_\_\_\_\_ months

Additional order(s) \_\_\_\_\_

**Pre-Treatment Medications:**

- Tylenol (acetaminophen) 650 mg po x 1 dose 30 minutes prior to treatment
- Zyrtec 10 mg po 30 minutes prior to treatment
- Benadryl (diphenhydramine) 25 mg IV push x 1 dose 30 minutes prior to treatment
- Solumedrol 125 mg IV push x 1 dose 30 minutes prior to treatment
- Other \_\_\_\_\_
- O2 at \_\_\_\_\_ liters per NC

**Adverse Reaction:**

- Benadryl 25 mg IV push x 1 for rash, hives or itching **if no allergy exists**
- Solumedrol 125 mg IV push x 1 for rash, hives or itching **if no allergy exists**
- Epinephrine (1:1000) 0.3 mg (0.3 mL) IM x 1 for Respiratory Distress
- O2 per oxymask to maintain O2 saturation above 94%
- Give all the above medications for an anaphylactic reaction as evidenced by: swelling of tongue, lips, and throat, trouble breathing, wheezing, abdominal pain, vomiting, dizziness, rash, hives, itching.
- Anaphylaxis - stop infusion immediately, maintain IV patency with Normal Saline, notify ordering provider and prepare to transfer to Emergency Department

Provider:

DATE:	TIME:	SIGNATURE:
-------	-------	------------

Printed Provider Name: \_\_\_\_\_

Phone number of referring provider: Phone # \_\_\_\_\_

Fax Number of referring provider: Fax # \_\_\_\_\_

Reviewed & Approved Dr. Saab 05/18/2022

