



Phone: (865) 862 - 4557

www.heartlandinfusion.com

Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

Cinqair Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status:	<input type="checkbox"/> New referral	<input type="checkbox"/> Dose or frequency change	<input type="checkbox"/> Order Renewal
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PATIENT INFORMATION

Name: _____			
Home Phone: _____		Cell Phone: _____	
Email: _____		Last four Social Security number _____	
DOB: _____		Height: _____	Weight: _____
Allergies: _____			
ICD-10 Diagnosis Code: _____		Years with Disease: _____	
TB Test (Circle One):		Chest Xray	Date: _____
<input type="checkbox"/> Skin	<input type="checkbox"/> Quantiferon	Result: _____	

LABORATORY ORDERS

<input type="checkbox"/> CBC w/ Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Quantiferon TB (annually)		Due:	_____
<input type="checkbox"/> Other			_____

Therapy Orders

Administer Cinqair (reslizumab) _____ mg at _____ mg/kg IV every 4 weeks

OR

(specify): _____

Nursing per Heartland Nursing Procedures (including reaction management)

DAW - Do not round to nearest vial size

<input type="checkbox"/> Pre-Medications	<input type="checkbox"/> No routine pre-medications required
<input type="checkbox"/> Tylenol (acetaminophen) _____ mg PO	<input type="checkbox"/> Zyrtec (cetirizine) 10 mg PO
<input type="checkbox"/> Solu-Medrol (methylprednisolone) _____ mg IV	<input type="checkbox"/> Claritin (loratadine) 10 mg PO
<input type="checkbox"/> Benadryl (diphenhydramine) _____ mg <input type="checkbox"/> PO	<input type="checkbox"/> IV
<input type="checkbox"/> Other: _____	

PHYSICIAN INFORMATION

Physician's Name: _____		
License #: _____	NPI#: _____	DEA#: _____
Address: _____		
City: _____	State: _____	Zip: _____
Office Contact: _____	Email: _____	
Office Phone: _____	Office Fax: _____	

Physician Signature: _____ Date: _____

Patient is being referred to: Knoxville Morristown Kingsport