



CINQAIR ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis

J45.50 Severe persistent asthma, uncomplicated J45.51 Severe persistent asthma with acute exacerbation
Type of asthma (allergic, eosinophilic, steroid-dependent, etc.): _____

■ Details Needed for Approval *Please answer all questions and provide supporting documentation.*

For initiation of therapy:

- What is the patient's recent baseline blood eosinophilic count? _____ cells/mcl Is baseline on or not on steroids? _____
- Does the patient have uncontrolled or poorly controlled asthma symptoms? _____
- Has the patient had ≥2 exacerbations per year requiring oral steroid treatment? _____
- Has the patient had ≥1 exacerbation per year requiring ER or hospitalized treatment? _____
- Is the patient's asthma inadequately controlled on mid-to-hi inhaled steroids plus an additional inhaled medication? _____
- Cigna: Please provide the patient's results of FEV1 (as % of predicted) and FEV1/FVC as baseline, between visits, after administration of short-acting bronchodilator, on positive exercise challenge, and on positive bronchial challenge.
- Will the patient continue to use maintenance asthma treatments (e.g. inhaler) in combination with Cinqair? _____
- Will the patient be concurrently treated with another biologic therapy for this condition? _____
- Is the patient being prescribed Cinqair for other eosinophilic condition, acute bronchospasm or status asthmaticus? _____
- Please provide documentation of the baseline clinical status, including forced expiratory volume and # of exacerbations in past 6 mo., steroid use in past 6 mo., rescue med use in past 6 mo., and # of hospitalizations or ER visits in the past 6 mo.s.

For continuation of therapy:

- Has the patient's asthma control improved while on Cinqair? _____ If yes, describe: _____
- Will the patient continue to use maintenance asthma treatments (e.g. inhaler) in combination with Cinqair? _____
- Will the patient be concurrently treated with another biologic therapy for this condition? _____

■ Medication Order

Cinqair (reslizumab) 3mg/kg by IV over 20-50 minutes every four (4) weeks for one (1) year.

Follow manufacturer's instructions in preparation and administration of medication. Gently invert the bag to mix. Do not shake the vial or the bag. Use an in-line 0.2µ filter. If refrigerated, allow the bag to come to room temperature. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

■ Rescue Management in Case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.