CINQAIR (RESLIZUMAB) Referral Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Rqd.)* ☐ Verify Benefits Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

_____

Office Contact: _____

Phone # & Ext.: _____ _____ Fax #: _____

Direct Message Address _____

CINQAIR MEDICATION ORDERS

Dose: ☐ 2 vials (200mg) ☐ 3 vials (300mg) ☐ 4 vials (400mg) ☐ 5 vials (500mg) ☐ Other _____

Patient Weight: _____ kg Frequency: ☐ every 4 weeks

DIAGNOSIS/INDICATION

☐ J.45.50 Severe persistent asthma, uncomplicated

☐ Other _____

***ICD-10** _____ **required**

_____ _____

Ordering Provider's Signature Date

NOTES (ADDITIONAL INFO)

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY