

Cinqair® Infusion Referral Form



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 Warrensville Heights, OH 44128
 Phone: 800-552-8442
 Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Info.	Prescriber: _____ NPI: _____ Phone: _____ Fax: _____ Office Contact: _____ Address: _____	
Patient Information	Name: _____ DOB: _____ <input type="checkbox"/> M <input type="checkbox"/> F Address: _____ Phone: _____ 2 nd Phone: _____ MRN: _____ Primary Language: _____ Functional Limitations: _____	
Clinical Information	Diagnosis (Include ICD-10 code): _____ Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior treatments & reason for discontinuation: _____ _____ Has the patient previously received Nucala® or Xolair®? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, were any signs of allergic reaction observed? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this the patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last dose: _____) Response to prior doses: _____ Has the patient ever had an anaphylactic-type reaction to a medication or food? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a history of parasitic infection? <input type="checkbox"/> Yes <input type="checkbox"/> No Is patient up-to-date with immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Home Care to provide immunizations in conjunction with current guidelines Additional Notes: _____ _____ _____	
Prescription Information	Cinqair® Dosing Regimen	Quantity
	<input type="checkbox"/> 3mg/kg in 50mL NaCl 0.9% infused over 20-50 minutes every 4 weeks.	_____ doses
	<input type="checkbox"/> Other dosing: _____	_____ doses
	Based on the clinical judgment of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: <input type="checkbox"/>	
	Supply Items: Must be infused through infusion set containing a sterile, non-pyrogenic, low-protein-binding filter with pore size of 0.2µm.	
	Site of Care: Home Care Infusion Center	
Prescriber Signature	My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above. Signature: _____ Date: _____	
<small>Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error please notify the sender noted above and destroy all transmitted material.</small>		