Cinqair Infusion Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: ◯ J45.50 Severe persistent asthma

◯ Other _____

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

◯ Clinical/ Progress Notes

◯ Demographics Sheet

◯ Current Medications

◯ Labs

CINQAIR ORDER

Cinqair Dose: ◯ 2 vials (200mg) ◯ 3 vials (300mg) ◯ 4 vials (400mg) ◯ 5 vials (500mg) ◯ Other: _____mg

Frequency: ◯ Every 4 weeks

Pre-treatment EOS serum: _____cells/uL

Date of last Cinqair Infusion: _____

*** **NOTE:** Patient **must have** an EpiPen/ epinephrine in their possession at each appointment date.***

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature_____ **Date:** _____