Cinqair® Infusion Referral Form

University Hospitals Home Care Services

4510 Richmond Road
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:** _____ ☐ **M** ☐ **F**

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 code): _____

Weight:_____ ☐ lb ☐ kg **Height:**_____ ☐ in

Allergies: _____ **Latex allergy?** ☐ Yes ☐ No

Prior treatments & reason for discontinuation: _____

_____

Has the patient previously received Nucala® or Xolair®? ☐ Yes ☐ No If yes, were any signs of allergic reaction observed? ☐ Yes ☐ No

Is this the patient's first dose? ☐ Yes ☐ 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? ☐ Yes ☐ No

Does the patient have a history of parasitic infection? ☐ Yes ☐ No

Is patient up-to-date with immunizations? ☐ Yes ☐ No ☐ Home Care to provide immunizations in conjunction with current guidelines

Additional Notes:

_____

_____

_____

Prescription Information

Cinqair® Dosing Regimen	Quantity
☐ 3mg/kg in 50mL NaCl 0.9% infused over 20-50 minutes every 4 weeks.	_____ doses
☐ 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: ☐

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:** _____