



Cinqair (Reslizumab)

INFUSION THERAPY CENTERS

New Referral Restart Medication Order Change

PATIENT INFORMATION

Name _____
Date _____
DOB _____
SS# _____
Phone # _____
Email _____

PHYSICIAN INFORMATION

Referring Physician _____
Practice Address _____
Office Contact Name _____
Contact Phone # _____ Fax # _____
NPI / TIN _____

MEDICATION ORDERS

Dosing: 2 vials (200mg) 3 vials (300mg) 4 vials (400mg) 5 vials (500mg) Other _____
Patient Weight: _____kg Frequency: every 4 weeks
Indication / Diagnosis:
 J.45.50 Severe persistent asthma, uncomplicated
 Other (*please specify in additional information*)
ICD-10 (Required) _____
MD Signature _____ Date _____

Additional Information:

REQUIRED DOCUMENTATION

Please send the following documents and records. This will help streamline the pre-authorization process.

- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- If this is a continuation of a treatment, include the last infusion note
- Current medication list

Most recent diagnostics results to include:

- Eosinophil phenotype (EOS) (drawn within the last 3 months)
- If available, radioallergosorbent test (RAST) results

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

AZIVinfusion.com | CALL CENTER: 602.386.4968 | FAX: 623.594.8533

FLAGSTAFF
399 S. Malpais Lane, Suite 108
Flagstaff, AZ 86001

GILBERT
2451 E. Baseline Rd, #425
Gilbert, AZ 85234

MESA
2152 S. Vineyard, Ste. 129
Mesa, AZ 85210

PHOENIX
9520 West Palm Lane, Ste. 220
Phoenix, AZ 85037-4442

SAN TAN VALLEY
36359 N. Gantzel Rd, Suite103
San Tan Valley, AZ 85140

TUCSON
2001 W. Orange Grove Road, Suite
104
Tucson, AZ 85704

GILBERT
3645 South Rome Street, Suite 201
Gilbert, AZ 85297

GLENDALE
5681 W. Beverly Lane, Suite 100
Glendale, AZ 85306-9802

PARADISE VALLEY
4550 E. Bell Rd, Bldg. 8, Suite 170
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Prescott, AZ 86301

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