(reslizumab)

CINQIAR Infusion Orders

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

☐ _____Severe Allergic Asthma with Eosinophilic Phenotype
☐ _____(Other)

PRE-MEDICATION:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____Other

☐Solu-Medrol 125mg IVP
☐Solu-Cortef 100mg IVP
☐Diphenhydramine 25mg IVP
☐_____Other

CINQAIR ORDERS:

DOSAGE/FREQUENCY:

⬭ **3mg/kg IV every 4 weeks**

● ***Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy***

PATIENT WEIGHT

_____LBS
_____KG

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Establish and maintain IV access / may use central venous access if appropriate and maintain per Specialty Infusion Center policy
- Flush IV with 3ml-5ml of saline before and after every IV medication and PRN
- Administer infusion medication/injection as ordered
- If mild itching, slow down the infusion and monitor patient closely
- If anaphylactic reaction, stop infusion, implement emergency medications, and plan and call 911
- When infusion complete, flush IV with 3ml to 5ml saline flush or 50ml bag of saline and discontinue IV per INS Standards
- Evaluate effectiveness of infused therapy on disease process
- Lab work per physician when ordered

ORDERING PROVIDER:

Signature _____ Printed Name: _____Date_____

Practice _____Phone_____ Fax _____

PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058

REV: 3/2023