

RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Cinqair Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Contact Fax #:	Office Contact Email:

Cinqair Medication Orders

Dosage <ul style="list-style-type: none">• ____ 3mg/kg IV once every 4 weeks• ____ Other _____ Patient Weight: ____ Lbs or ____ Kg	
Diagnosis with ICD 10 code (REQUIRED) <ul style="list-style-type: none">• Diagnosis: ____ Asthma, Severe Eosinophilic ____ Other _____• ICD 10 code _____	
Pre-Medication <ul style="list-style-type: none">• Tylenol ____ mg • Benadryl ____ mg __ IV or __ PO• Solumedrol IV Push ____ mg • Other _____	Refills <ul style="list-style-type: none">• Zero ____ • Treatments for 1 year _____• Other _____

Required Documentation

• Insurance Cards (Front and Back)	• Patient Demographics • Lab Results – CMP, CBC	• Recent Progress Notes
Special Instructions/Notes		

Prescribing Provider Signature

Date of Signature