Reslizumab (Cinqair)

Provider Order Form

IVX HEALTH

PATIENT INFORMATION

Date:	Patient Name:		DOB:
ICD-10 code (required):		ICD-10 description:	
☐ NKDA Allergies:			Weight lbs/kg:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy	Next Due Date (if applicable):	

PROVIDER INFORMATION

Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

NURSING

☑ Provide nursing care per IVX Standard Nursing Procedures, including reaction management

THERAPY ADMINISTRATION

☐ **Reslizumab** (Cinqair) in 50ml 0.9% sodium chloride intravenous infusion over 25-50 minutes
- Dose: ☐ 3mg/kg
  ☐ round up to nearest whole vial
  ☐ give exact dose
- Route: intravenous
- Frequency: ☐ every 4 weeks

☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ Patient is required to stay for 30-minute observation post infusion/injection

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Ordering Provider: Initial here _____ and proceed to the next page.

ADULT REACTION MANAGEMENT PROTOCOL

☑ Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation, nausea, vomiting

☑ If reaction occurs:

- Stop infusion.
- Maintain/establish vascular access.
- Notify referring provider as clinically appropriate and follow clinical escalation protocol.
- IVX Health clinicians have the following PRN medications available for the following reactions.
  - Headache, pain, fever >100.4F, chills or rigors- Acetaminophen 650mg PO or Ibuprofen 400mg PO.
  - Mild Hives, itching, redness, or rash- Loratadine 10mg PO or Diphenhydramine 50mg PO.
  - Severe hives, itching, redness, or rash- Diphenhydramine 25-50mg SIVP.
  - Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg ODT (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg PO.
  - Severe Nausea, vomiting, heartburn, acid reflux- Ondansetron 4mg SIVP (may repeat x 1 in 20 minutes if nausea continues, max dose 8mg) or Famotidine 20mg SIVP.
  - Hypotension (90/60), vasovagal response- Place patient in reclined position, administer 0.9% Sodium Chloride IV 250ml. May repeat to keep BP >90/60, maximum of 1000ml, monitor vital signs.
  - Chest pain/discomfort, shortness of breath- Oxygen 2-15 liters, titrate to keep Spo2 >92%.
  - Solumedrol 125mg IV- Refractory to other treatments given.
  - Other _____
- When symptoms resolve resume infusion at 50% previous rate and increase per manufactures guidelines.

☑ **Severe allergic/anaphylactic reaction:**

- If symptoms are rapidly progressing or continuing after administration of PRN medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
  - Call 911.
  - Initiate basic life support as needed.
  - Bring the **AED** to the patient (Attach pads if indicated).
  - **Epinephrine**- administer 0.3mg of a 1:1,000 (1mg/ml) concentration intramuscularly (preferably outer thigh), may be repeated every 5-15 minutes as needed to a maximum of 3 doses.
  - Place patient in recumbent position, elevate lower extremities.
  - **Oxygen**- administer 2-15 liters/minute or 100 percent oxygen as needed maintain SpO2 >92 percent.
  - **IV Fluids**- Treat hypotension with normal saline bolus of 500ml, repeat as needed to maintain systolic BP >90.
  - Administer **diphenhydramine** 50mg IV or Famotidine 20mg IVP, if not previously given.
  - Administer **methylprednisolone** 125mg IVP, if not previously given.
  - Continuous monitoring of blood pressure, pulse oximetry, and heart rate.
  - Notify clinical executive, DON or CMO, when appropriate. Must be done same day. Do not delay treatment.

Patient Name	**Patient Date of Birth**
Provider Name (Print)	
Provider Signature	**Date**

Email ivxintake@ivxhealth.com or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

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