MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

CINQAIR® (RESLIZUMAB) REFERRAL

(- Required Fields)*

____ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Referral Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐ M ☐ F
ADDRESS:		PHONE:	
WEIGHT: ☐ LBS ☐ KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION			
PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:	

CINQAIR Infusion*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

____ Dosing: 3mg/kg IV every 4 weeks

Physician Signature* _____
***NPI#** _____

Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Severe Asthma
_____ Eosinophilic Asthma
_____ Other_____

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics
_____ Insurance Card/Information
_____ Clinical/Progress Notes supporting DX
_____ Current Medication List and H&P
_____ Absolute Eosinophil Count (> 300 in prior 12mos or > 150 in prior 6 weeks)

Last Infusion/Injection Date: _____

STANDING LAB ORDERS (to be drawn at the clinic): _____ CMP _____ CBC *Frequency _____

FOR MPP USE ONLY

Referral Reviewed and Accepted by: _____ *Date approved:*_____
Additional information needed/ notes:

Locations:

--------Colorado--------
☐ Lakewood

------Oklahoma--------
☐ Tulsa

---------Florida---------
☐ Jacksonville
☐ Kissimmee
☐ Port St. Lucie
☐ Suncoast
☐ Winter Park

----------Texas----------
☐ Arlington
☐ Cedar Hill
☐ Dallas
☐ Denton
☐ Ft. Worth
☐ Irving
☐ Rockwall
☐ Southlake
☐ Flower Mound
☐ Plano
☐ Tyler

REVISION DATE- 1/2022