MEDICA HEALTHCARE SERVICES
INJECTIONS AND INFUSION SPECIALTY
CHRONIC & RARE DISEASES

CINQAIR Medication Order Form

Patient Name: _____ DOB: _____

Phone Number: _____ ☐ Male ☐ Female

DIAGNOSIS *please provide ICD-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
☐ Diphenhydramine 25mg PO
☐ Solu-Cortef 100mg IVP
☐ _____
(other)

CINQAIR ORDERS

DOSAGE

☑ 3mg/kg IV every 4 weeks

PATIENT WEIGHT

_____ lbs

_____ kg

NOTES

PRESCRIBER INFORMATION

Signature: _____ Date: _____

Provider's name: _____ Fax: _____

Physician NPI: _____ Physician's DEA: _____

PLEASE SELECT PREFERRED PATIENT LOCATION:

- ☐ 105 Commerce St, # 109, Lake Mary, FL 32746
- ☐ 4850 W Oakland Park Blvd, #104, Lauderdale Lakes, FL 33313
- ☐ 3401 PGA Blvd, STE 540, Palm Beach Gardens, FL 33410
- ☐ 5210 Linton Blvd, STE 207, Delray Beach, FL 33484
- ☐ 3654 SW 30th Ave, Palm City, FL 34990

PLEASE FAX ORDER TO:

Fax: 561-207-7848

Phone: 689-488-1430

info@medicainfusion.com

www.medicainfusion.com