Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Cinqair Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 attn: Idyllic Infusion Coordinator

Is this a Continuation of Care or a new start to the medication?

- ☐ Continuation of Care (Provide documentation of last administration)
- ☐ New Rx

DATE:	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact **Name:** **Phone:** **Email:**	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _________ WKS / MOS**	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	

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DATE:	
Preferred Treatment Location	▢ Voorhees ▢ Moorestown ▢ Wall/Manasquan ▢ Sewell ▢ Hamilton ▢ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

Name (last, first) __________________________________DOB: __________________

Diagnosis:
☒ J45.50 Severe persistent asthma, uncomplicated
☒ J45.51 Severe persistent asthma, with (acute) exacerbation
☒ J45.52 Severe persistent asthma, with status asthmaticus
☒_____ Other: ____

The following information is required for authorization for Cinqair:

- Pre-treatment pulmonary function test:
  FEV-1 <80% predicted
  ☒ FEV-1 reversibility ≥12% and 200mL after albuterol administration
  ☒ Other
- What is the patient's peripheral blood eosinophil count? __________ cells/mcL; Date drawn: _____________
- Has the patient had >3 asthma exacerbations in the past year? ▢ Yes ▢ No
- If yes, please select all that apply:
  - Oral steroids were required for at least 3 days ▢ Yes ▢ No
  - Exacerbation resulted in an ED visit and/or hospitalization ▢ Yes ▢ No
- Has the patient been compliant on high dose ICS/LABA inhalers for at least 3 months? ▢ Yes ▢ No
- Will the pt. be using cinqair with another biologic? ▢ Yes ▢ No
- In the past 6 months, what medications for the above diagnosis has the patient tried and failed?
  ____

PLEASE NOTE:

- Please attach a copy of medication order to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*

- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- *-Please notify our office if the medication will be discontinued.*

☐ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: ____