

# Benralizumab (Fasenra)

Provider Order Form rev. 12/23/2021



## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight lbs/kg: \_\_\_\_\_

**Patient Status:**  New to Therapy  Continuing Therapy Next Due Date (if applicable): \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## ICD-10 Code

- J45.50 severe asthma aged 12 years and older with an eosinophilic phenotype
- Other: \_\_\_\_\_

## MEDICATION ORDER

- Benralizumab** (Fasenra)
  - Dose:  30mg
  - Route:  subcutaneous injection
  - Frequency:  every 4 weeks for 3 doses followed by every 8 weeks /  every 8 weeks
- Patient is required to stay for 30-minute observation period
- 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.

Provider Name (Print) \_\_\_\_\_ Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

## REQUIRED DOCUMENTATION

- Recent Office notes (along with any therapies tried and outcomes)
- Lab Results
- Insurance Cards (front and back)
- Current Medication
- Demographic Sheet
- History and Physical Report

## ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ANA (SLE)
- Comprehensive Metabolic Panel, CBC with differential w/in past 3 months