



Fasenra

Provider Order Form

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Patient Home Phone: _____ Patient Cell Phone: _____ Patient Email: _____

Emergency/Alternate Contact Name: _____ Emergency/Alternate Contact Phone: _____

NKDA Allergies: _____ Weight lbs/kg: _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): _____

REQUIRED DOCUMENTATION

Labs Insurance Card (front and back) Current Medications History/Progress Notes

ICD-10 CODE

M30.1 Polyarteritis with lung involvement (EGPA/Churg-Strauss) J45.50 Severe, persistent asthma

Other: _____

PRE-MEDICATION ORDER

Acetaminophen (Tylenol) 500mg 650mg 1000mg PO **Diphenhydramine** (Benadryl) 25mg 50mg PO IV

Cetirizine (Zyrtec) 10mg PO **Methylprednisolone** (Solu-Medrol) 40mg IV 125mg IV

Loratadine (Claritin) 10mg PO **Hydrocortisone** (Solu-Cortef) 100mg IV

Other: _____ Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Fasenra (benralizumab) **Dose** 30mg SC **Frequency:** Every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter
 Every 4 weeks
 Every 8 weeks

PROVIDER INFORMATION

Provider Name: _____ Provider Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

SPECIAL INSTRUCTIONS

Provider Name _____ Provider Signature _____ Date Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.