Fax Form to: 330-294-2082

INDY INFUSION

Benralizumab (Fasenra)

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per Nursing Procedures, including reaction management and post-procedure observation

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ 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

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____

(if not indicated order will expire one year from date signed)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Fasenra:

*List of current medications treating disease
*Lab results showing eosinophil count
*Clinicals showing number of asthma exacerbations in the last 12 months
*Clinicals showing that the patient has severe asthma and has an eosinophilic phenotype
*FEV1 test results