Benralizumab (Fasenra)

Provider Order Form rev. 11/06/2023

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

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

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Severe Persistent Asthma:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer Fasenra 30mg subcutaneously

☑ One-hour post-injection observation period mandatory for all patients every visit unless waived by referring provider.

FREQUENCY *(Choose one)*

☐ Induction: week 0, 4, 8, and then every 8 weeks

☐ Maintenance: every 8 weeks

☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- current parasitic infection
- new or worsening asthma symptoms since initiating Fasenra

☑ If indicated as required by provider, confirm patient has epinephrine auto-injector and understands indications for use.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with steroids, FEV1 level, exacerbations/flares in 12 months, hospitalizations in 12 months, FVC, Percent of body area covered for atopic dermatitis and eosinophil levels.

Required Labs: Eosinophil levels, CRP/ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.