



# Fasenra® Order Form (benralizumab)

FAX TO: 972.499.9210

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M F  
 Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs kg Primary Language: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Patient Preferred Location: \_\_\_\_\_

## Diagnosis

### ICD 10 Code (Required)

J45.51 Severe Persistent Asthma, w/Acute Exacerbation  
 J45.50 Severe Persistent Asthma, Uncomplicated

Other ICD 10 Code: \_\_\_\_\_  
 Description \_\_\_\_\_

### Patient Status

New to therapy  
 Continuing therapy (date of last dose \_\_\_\_\_)

## Medication Order

### FASENRA (benralizumab)

#### Loading Dose:

SubQ: Inject 30 mg every 4 weeks for first 3 doses  
 followed by once every 8 weeks thereafter x1 year

#### Maintenance Dose:

SubQ: Inject 30 mg every 8 weeks for 1 year

**Adverse Events:** In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol

#### Comments:

## Required Clinical Documentation

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

**Medix Infusion will collect all necessary labs if not included in referral documents**

## Referring Provider Information

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Supervising Physician: \_\_\_\_\_ (If Applicable)  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_