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**

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____ Date: _____

Prescriber Name: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____