

Fasenra (Benralizumab) Referral Form



REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics and insurance information
- ☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis (ICD-10 below)
- ☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	
Diagnosis: ☐ Severe Allergic Asthma with eosinophilic phenotype (ICD-10 _____) ☐ Other (ICD-10 _____)		
Initial Dose: ☐ 30 mg subcutaneously on weeks 0, 4, and 8 Maintenance Dose: ☐ 30 mg subcutaneously every 8 weeks starting on week 16 Refill: ☐ PRN x 1 year OR _____ times		
Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician Labs: _____ Frequency: _____		
Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed		
Nursing Orders: ☐ Pharmacy to provide nursing services for initial administration and teaching and as needed ☐ May use Burnham's Vital Care anaphylaxis protocol as needed		
Additional Instructions: 		
Practitioner Name:	Practitioner Signature:	Date:
Practitioner Address:		

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