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: