



### Fasenra (Benralizumab) Subcutaneous Injection Order Form

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F

Allergies: \_\_\_\_\_

New Treatment     Continuing Treatment    Last Treatment Date: \_\_\_\_\_    Next Due Date: \_\_\_\_\_

**Diagnosis and ICD 10 Code (Required)**

Severe Eosinophilic Asthma    ICD 10 Code: J45.50

**Required Tests (within 12 months & attach results)**

Pulmonary Function Test    Results \_\_\_\_\_

Blood Eosinophil Counts    Results \_\_\_\_\_

**Nursing**

Provide nursing care per Smart Infusion Nursing Procedures,  
Including reaction management and post-procedure observation.

**Special Instructions / Notes**

<b>Fasenra Medication Order</b>
<b>Patient Weight:</b> _____ KG
<b>Initial Dosage</b> – Subcutaneous Injection
<input type="checkbox"/> 30mg
<b>Frequency</b>
<input type="checkbox"/> Initial dosing every 4 weeks for 3 doses
<input type="checkbox"/> Other _____
<b>Maintenance Dosage</b>
<input type="checkbox"/> 30mg
<b>Frequency</b>
<input type="checkbox"/> Every 8 weeks
<input type="checkbox"/> Other _____

<b>Required Documents</b>
<input type="checkbox"/> Patient Demographic Sheet
<input type="checkbox"/> H & P within the past 6 months
<input type="checkbox"/> Current Medication List
<input type="checkbox"/> Clinical & Progress Notes (including last infusion note)
<input type="checkbox"/> Copy of Insurance Card (Front/Back)

<b>Location</b>
<input type="checkbox"/> Eau Claire <input type="checkbox"/> Weston <input type="checkbox"/> Middleton

**Provider Information**

Provider Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_