Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
MedFuse

Fasenra (Benralizumab) Injection Order

Patient Name: DOB: □ Male □ Female

Diagnosis (please provide ICD10 code):

□ Other:

□ NKDA □ Allergies:

□ New Therapy Order □ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip:

Pre-Medication

□ Acetaminophen _____mg by □ PO
□ Ceterizine _____mg by □ PO
□ Diphenhydramine _____mg by □ PO/ □ IVP
□ Solu-Medrol _____mg by □ PO/ □ IVP
□ Solu-Cortef _____mg by □ PO/ □ IVP
□ Other:

Required Documentation:

□ Patient Demographics
□ Patient Insurance (med and pharm card copies, front and back)
□ Progress Notes/Labs supporting diagnosis
□ Poor spirometry
□ CBC, Absolute Eosinophil Count
□ Other:

Patient Height and Weight

Patient Height (cm): Patient Weight (kg):

Fasenra Medication Order (Please select ONE):

□ Induction dosing on weeks 0, 4 and 8, followed by maintenance
- ▪ Dosing (Please choose one)
  - □ 30 mg
  - □ Other: _____
- ▪ Maintenance Frequency (Please choose one)
  - □ Every 8 weeks
  - □ Other: _____

□ Maintenance dosing every 8 weeks only
- ▪ Dosing (Please choose one)
  - □ 30 mg
  - □ Other: _____

Additional Instructions/Notes:

Ordering Provider:

Signature: _____ Date: _____

Provider: _____ Phone: _____ Fax: _____

Best Contact Person in Office: _____ Phone: _____

Updated: 3/29/2024