

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
- Cetirizine _____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
- Spirometry results
- CBC, Absolute Eosinophil Count
- Other: _____

Patient Height and Weight

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

Fasenra Medication Order (Please select ONE):

- Subcutaneous 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: _____
- Subcutaneous 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: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400