Fasenra
(benralizumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Moderate persistent asthma, uncomplicated (J45.40)
☐ Severe persistent asthma, uncomplicated (J45.50)
☐ Severe persistent asthma with acute exacerbation (J45.51)
☐ J45.901 Unspecified asthma with (acute) exacerbation
☐ Other: _____

PRESCRIPTION

Fasenra:

☐ Initial Dose: Fasenra 30mg subQ every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter x 1 year

☐ Maintenance Dose: Fasenra 30mg subQ every 8 weeks x 1 year

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Tried/Failed Therapies
- Eosinophil count
- PFT

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol.
(See aiscaregroup.com for detailed policy)
- Epinephrine (weight-based dosing) PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended pre-medications for this medication.
☐ Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.