Fasenra Injection Order (benralizumab)

Fax completed order to: 334-521-0394

Infusion Care of East Alabama

InfusionCare.org
P: 334-521-0073

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Medications ☐ H & P Relevant to the Diagnosis ☐ CBC (Eosinophil Count)

This information is necessary for prior authorization approval and to ensure payment by the insurance carrier.

Patient Information

Date of Referral

First Name | M.I. | Last Name

Date of Birth

Address

City | State | Zip Code

Phone

Wt (kg) | Ht (in)

Diagnosis

- ◯ J45.50 Severe Persistent Asthma, Uncomplicated
- ◯ J45.51 Severe Persistent Asthma with (acute) exacerbation
- ◯ J82.83 Eosinophilic Asthma

Other orders or special instructions

Office Contact Person

Office Contact Email or Phone Number

Fasenra Dosing

◯ Administer 30mg subcutaneous injection every 4 weeks for the 1st 3 doses, then every 8 weeks thereafter.

◯ Administer 30mg subcutaneous injection every 8 weeks.

Refill _____ times

*PER OUR PROTOCOL, Patient will be monitored for 10 mins after injection.

Prescribing Provider

Address

City | State | Zip Code

Provider Phone

Provider Fax

Provider NPI | Provider Tax ID

PROVIDER SIGNATURE (NO STAMPS)

Date/Time