

FASENRA® (benralizumab)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
DOB: _____ Allergies: NKDA _____
Phone Number: _____
Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List Recent labs including eosinophil count
 Clinical/Progress Notes Supporting Dx Pulmonary Function Test

Primary Diagnosis

 ICD-10 Code (required): _____

- Severe asthma Other: _____
 Eosinophil Granulomatosis with Polyangiitis (EGPA)

Therapy Administration

- Induction: Fasenra 30mg subQ every 4 weeks for 3 doses followed by every 8 weeks Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 Maintenance: Fasenra 30mg subQ every 8 weeks RN to administer ordered therapy per manufacturer guidelines.
 Other: _____ Other: Please fax alternative reaction orders or nursing administration orders if checking this box

Refills:

- x 1 year Other: _____

 Order valid for one year unless otherwise stated

Special Orders

Provider Information

Provider Name: _____ Office Contact Person: _____
Referring Practice Name: _____ Phone Number: _____
Referring Practice Address: _____ Fax Number: _____
City, State, Zip: _____ Email: _____
Provider NPI: _____
Provider Signature: _____ Date: _____