

# 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: \_\_\_\_\_