

FASENRA (benralizumab) Injection Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

☐ _____ Severe Eosinophilic Asthma ☐ _____ *(other)*

Previous Drug Therapies/Tried & Failed:

☐ Cinqair ☐ Nucala ☐ Xolair ☐ Other: _____ Date of last dose: _____

Pre-Medication:

☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Cetirizine 10mg PO ☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☒ Patient Demographic Sheet
☒ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☒ Blood Eosinophil result & date *(please attach)*

FASENRA ORDERS:

Dosing/Frequency: ☐ Induction: 30mg every 4 weeks for first 3 doses, then every 8 weeks

☐ Maintenance: 30mg every 8 weeks

☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☒ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____