

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation
- J82.83 Eosinophilic Asthma
- J30.1 Polyarteritis with lung involvement [EGPA/Churg-Strauss]
- ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- Insurance Information
- List of Medications
- Tried & Failed Therapies
- Most Recent History & Physical
- Lab results and/or Pulmonary Function Tests to support diagnosis
- Blood Eosinophil Level/CBC

MEDICATION ORDER

*FOR PEDIATRIC PATIENTS AGED 6 – 11 WEIGHING LESS THAN 35KG

- LOADING:** Fasenra® (benralizumab) 10mg via subcutaneous injection every 4 weeks FOR 3 doses
- MAINTENANCE:** Fasenra® (benralizumab) 10mg via subcutaneous injection every 8 weeks

*FOR PEDIATRIC PATIENTS AGED 6 – 11 WEIGHING GREATER THAN 35KG OR ADOLESCENT PATIENTS AGED 12 OR OLDER

- LOADING:** Fasenra® (benralizumab) 30mg via subcutaneous injection every 4 weeks initial 3 doses
- MAINTENANCE:** Fasenra® (benralizumab) 30mg via subcutaneous injection every 8 weeks

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first injection and then for 15 minutes following each subsequent injection. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN