Patient Name:______________________________________

DOB:______________________ Wt(kg):_________________

Allergies:___________________ Phone:_________________

FASENRA (BENRALIZUMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Severe Asthma with eosinophilic phenotype (ICD-10: ________________)

☐ Other:_______________________________ (ICD-10: ________________)

Pt. Weight ____________ kg Allergies:____

FASENRA ORDERS

Fasenra ☐ Initial Dose: 30mg subcutaneously every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter

☐ Maintenance Dose: 30mg subcutaneously every 8 weeks

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	