HONORHEALTH

BENRALIZUMAB
(Fasenra)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status ☐ New Order ☐ Renewal ☐ Dose or Frequency Change

Diagnosis
☐ Asthma, severe eosinophilic
☐ Other: _____

Diagnosis Code: _____

Required Information

Allergies:

Negative Quantiferon TB or Tspot or chest x-ray	Date:	Weight: _____
Diagnostic Hepatitis B Panel	Date:	
Coccidioides Screen/Panel	Date:	Height: _____
CBC, CMP (include lab result documents)	Date:	

Labs ☐ CBC, CMP every _____ ☐ Other:

Fasenra (benralizumab)

Induction:
☐ 30mg SQ every 4 weeks for first 3 doses, then once every 8 weeks
☐ Other:

Maintenance:
☐ 30mg SQ every 8 weeks
☐ 30mg SQ every _____

☐ Other:

Infusion Reaction Medications Hypersensitivity Reaction Protocol will be utilized unless otherwise specified.

Required Documentation
- H&P or progress note supporting diagnosis
- Medication history
- Recent labs (as above) and/or diagnostic test results

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: