

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:

[illegible]

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