MRN:_____

DOB:_____

STANDARD FASENRA™ (benralizumab) PLAN OF TREATMENT

NOTE: Patient ***may be ineligible*** to receive **FASENRA™ (benralizumab)** if patient has signs/symptoms of a parasitic infection, is currently being treated for a parasitic infection, or is having and acute bronchospasm and/or asthma attack.

1. Patient Name:_____ Height (inches):_____ Weight (lbs):_____

2. Allergies: _____

3. Diagnosis:

☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ J45.50 Severe persistent asthma, uncomplicated

☐ Other **ICD-10 Code:**_____ **Diagnosis description:**_____

4. Dose/Frequency: (*Administer as subcutaneous injection only to upper arm, thigh, or abdomen*)

☐ **Induction dose:**
FASENRA™ (benralizumab) 30 mg subcutaneous injection every 4 weeks for the first (3) doses given at week 0, week 4, week 8

☐ **Maintenance dose as follows:**
FASENRA™ (benralizumab) 30 mg subcutaneous injection every 8 weeks.

Extended post treatment monitoring for any patient new to therapy: monitor patient for one (1) hour after first injection, for 30- minutes after second injection, and then 15-minutes after each injection thereafter.

Special orders:

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature:_____/_____ Date: _____
No Stamp Signatures **(Dispense as written)** **(Substitution permitted)**

Printed Physician's Name with Credentials:_____ NPI: _____

MRN:_____

DOB:_____

Guidelines for Prescribing FASENRA™ (benralizumab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or Pulmonary Function Tests to support diagnosis**.

- FASENRA™ (benralizumab) is an interleukin-5 receptor alpha-directed cytolytic monoclonal antibody (IgG1, kappa) indicated for the **add-on maintenance treatment** of patients with severe asthma aged 12 years and older, and with an eosinophilic phenotype.

☐ If patient is switching biologic therapies such as Xolair®, **Cinqair®**, or Nucala®, then MD must specify wash-out period prior to starting **FASENRA™** as specified of_____weeks.
Last known therapy:_____and last known date received:_____.

☐ Other as requested: _____

_____

Pre-Screening:

☐ Blood Eosinophil Level

** **Warnings/Precautions: Hypersensitivity reactions:** hypersensitivity reactions (e.g., anaphylaxis, angioedema, urticaria, rash) have occurred after administration of FASENRA™. Discontinue in the event of a hypersensitivity reaction. The most common adverse reactions (incidence greater than or equal to 5%) include headache and pharyngitis. • **Reduction in Corticosteroid Dosage:** Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy. Decrease corticosteroids gradually, if appropriate. • **Parasitic (Helminth) Infection:** Treat patients with pre-existing helminth infections before therapy with FASENRA™. If patients become infected while receiving FASENRA™ and do not respond to anti-helminth treatment, discontinue FASENRA™ until the parasitic infection resolves. Pregnancy/Breastfeeding: Discuss Pregnancy or breastfeeding plans/risks prior to start of therapy. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.