Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Fasenra™ (benralizumab) Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	J45.50 - Severe persistent asthma, uncomplicated	☐	J45.52 - Severe persistent asthma with status asthmaticus
☐	J45.51 - Severe persistent asthma with acute exacerbation	☐	J82.00 - Pulmonary eosinophilia, not elsewhere classified
☐	J82.83 - Eosinophilic Asthma		
☐	_____ - Other:_____		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Blood Eosinophil Level (CBC)		☐ **Continue current order until insurance approved**
6	Lab results/Pulmonary function test to support diagnosis (ex: FEV1 score)		

MEDICATION ORDERS:

NOTE: 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 for all subsequent injections.

DOSE/FREQUENCY:

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

☐ Maintenance: Fasenra™ (benralizumab) 30 mg subcutaneous injection every 8 weeks

SPECIAL ORDERS:

☐ _____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	