

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Fasenra® (benralizumab) Pediatric Standard Plan of Treatment for Asthma

### 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:
<input type="checkbox"/> See list	<input type="checkbox"/> NDKA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> 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	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	Blood Eosinophil Level (CBC)	THERAPY:	<b>Continue current order until insurance approved</b>
6	Lab results/Pulmonary function test to support diagnosis (ex: FEV1 score)		

### Provider Attestation for HCP administration:

<input type="checkbox"/> Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Fasenra product FDA labeled for self-administration	<input type="checkbox"/> Patient has experienced severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Fasenra within the past 6 months and requires administration and direct monitoring by a healthcare professional*
<input type="checkbox"/> Patient has a history of uncontrolled disease and ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug	<input type="checkbox"/> Due to patient's weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug
<input type="checkbox"/> The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.	

\*Specific reactions: \_\_\_\_\_

### MEDICATION ORDERS:

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

### DOSE/FREQUENCY FOR PEDIATRIC PATIENTS 6 TO 11 YEARS OF AGE WEIGHING LESS THAN 35KG:

<input type="checkbox"/> <b>Induction:</b> Fasenra™ (benralizumab) 10 mg/0.5 mL subcutaneous injection every 4 weeks for the first (3) doses given at week 0, week 4, week 8
<input type="checkbox"/> <b>Maintenance:</b> Fasenra™ (benralizumab) 10 mg/0.5 mL subcutaneous injection every 8 weeks If the patient is 6 to 11 years of age weighing more than 35kg, or 12 years of age or older, refer to the standard Fasenra POT for dosing.

### SPECIAL ORDERS:

<input type="checkbox"/>
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.
<input checked="" type="checkbox"/> Refills x 12 months unless noted otherwise here:

### 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
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## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)