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 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: ☐ See list ☐ NKDA	

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:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	Blood Eosinophil Level (CBC)
6	Lab results/Pulmonary function test to support diagnosis (ex: FEV1 score)

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INJECTION DATE:

NEXT INJECTION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

Provider Attestation for HCP administration:

☐ Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Fasenra product FDA labeled for self-administration

☐ 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

☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.

☐ 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*

☐ 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

*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:

☐ **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:

☐ _____

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.

☑ Refills x 12 months unless noted otherwise here:

NURSING ORDERS:

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.

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	