

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"/> 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	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	IF ORDER CHANGE:
5 Blood Eosinophil Level (CBC)	THERAPY:	Continue current order until insurance approved
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"/> Induction: 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"/> Maintenance: 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:

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
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