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

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:					
Patient's Phone:		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:		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)		

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:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.	Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

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	