oasis
FAMILY HEALTH NP RN

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Fasenra (Benralizumab)

PATIENT INFORMATION

Referral Status *(check one)*: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: ______________________ DOB: ______________

NKDA ☐ Allergies: ______________________ Weight ________ *Please specify:* ☐ lbs ☐ kg Height: ________

Patient Status *(check one)*: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: ____________ Next Due Date: ____________

ICD-10 code (required): ______________ ICD-10 description: ______________________

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

THERAPY ADMINISTRATION

☐ **Benralizumab** (Fasenra)

- Dose: ☐ 30mg
- Route: ☐ subcutaneous injection
- Frequency: ☐ every 4 weeks for 3 doses followed by every 8 weeks / ☐ every 8 weeks

☐ Patient required to stay for 30-min observation post procedure

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______________________
(if not indicated order will expire one year from date signed.)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: ______________________ Referral Coordinator Email: ______________________

Ordering Provider: ______________________ Provider NPI: ______________________

Referring Practice Name: ______________________ Phone: ______________ Fax: ______________

Practice Address: ______________________ City: ______________ State: ______ Zip Code: ______________

Provider Name (Print) ______________________ *Provider Signature* ______________________ *Date* ______________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK