(benralizumab)

FASENRA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Eosinophilic asthma

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ _____

☐ Length of Need _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

FASENRA ORDERS

DOSAGE

◯ Initial dose 30 mg every 4 weeks for the first 3 doses, then every 8 weeks

◯ Maintenance dose: 30 mg every 8 weeks

◯ _____ *(other frequency)*

PATIENT WEIGHT

_____ lbs.

_____ kg

◯ Refills: _____

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887