



6415 Fort Apache Road, Suite #175
Las Vegas, NV 89148
Phone: 702-665-5730
Fax: 702-780-4887

FASENRA (benralizumab) infusion orders

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Gender: _____ Height: _____ Weight: _____ (lb/kg)

Diagnosis

- _____ Eosinophilic Asthma
- _____
- _____

Pre-Medication

- Tylenol 1000mg PO
- Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Solu-Medrol 125 IVP
- Solu-Cortef 100mg IVP
- Diphenhydramine 25mg IVP
- _____
- _____

Orders

Frequency

- Initial dose 30 mg every 4 weeks for the first 3 doses, then every 8 week
- Maintenance dose: 30mg every 8 weeks
- _____ Refills

Notes

Ordering Provider

Signature: _____ Date: _____
Provider: _____ Phone: _____ Fax: _____
Address: _____
NPI: _____ DEA: _____