Infusion for Health
77 Rolling Oaks Drive, Suite 201
Thousand Oaks, CA 91361
Phone: 805-719-3700 Fax: 805-852-2636

FASENRA INJECTION ORDER (benralizumab)

Please fax a copy of patient's demographics, insurance, H&P relevant to the diagnosis, eosinophil labs, and current medications.

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

Fasenra (benralizumab) dosage:

30 mg subcutaneous injection every 4 weeks for the first 3 doses, then every 8 weeks thereafter

Please send eosinophil labs.

Blood eosinophil level: _____ Date: _____

Start date: _____/_____/_____

**** PER OUR PROTOCOL, ALL PATIENTS MUST HAVE EPINEPHRINE AUTO INJECTOR WITH THEM AT TIME OF INJECTION.**
Patient will be monitored for 30 minutes after injection

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office phone number: _____ Office Fax:_____

Office address: _____Contact person: _____