

# Fasenra Injection Order (benralizumab)



Ph: 805-719-3700 | Fax: 805-852-2636

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Treatment Location: \_\_\_\_\_

**\*Please fax a copy of the following patient information:**  Demographics  Insurance Information  Current Medications  
 H & P Relevant to the Diagnosis  Eosinophil Labs

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Allergies: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs / kg Height: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

ICD-10: \_\_\_\_\_

## PROVIDER INFORMATION

Printed Provider's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Office Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_

## FASENRA (BENRALIZUMAB) DOSAGE:

**30mg 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.**