Fasenra Injection Order

(benralizumab)

InfusionForHealth.com
Ph: 888-777-1945 | 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 ☐ CBC (Eosinophil Count)

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: _____

Contact Email: _____

FASENRA (BENRALIZUMAB) DOSAGE:

Date of Last Treatment, If Continuation:

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: _____