

| BENRALIZUMAB (FASENRA) PRESCRIBER ORDER FORM | | | | |
|---|---------|---|--------------|--|
| Patient Name: | | Date of Birth: | | Gender: |
| Address: | | | | |
| Phone: | Height: | <input type="checkbox"/> Inches <input type="checkbox"/> cm | Weight: | <input type="checkbox"/> lbs <input type="checkbox"/> kg |
| Clinical Information | | | | |
| Primary Diagnosis Description: | | | ICD-10 Code: | |
| Allergies: <input type="checkbox"/> NKDA OR (List): | | | | |
| BENRALIZUMAB (FASENRA) Medication Order | | | | |
| <p>Severe Eosinophilic Asthma (or patients aged 6 years and older who weigh ≥35 kg):</p> <p><input type="checkbox"/> 30 mg SUBQ every 4 weeks for first 3 doses followed by once every 8 weeks thereafter</p> <p>Severe Eosinophilic Asthma - Pediatric dosing (aged 6-11, <35 kg):</p> <p><input type="checkbox"/> 10 mg SUBQ every 4 weeks for first 3 doses followed by once every 8 weeks thereafter</p> <p>Eosinophilic Granulomatosis with Polyangiitis (for patients 18 years and older):</p> <p><input type="checkbox"/> 30 mg SUBQ every 4 weeks for first 3 doses followed by once every 8 weeks thereafter</p> <p><input type="checkbox"/> Other: _____</p> <p>Dispense refills x 1 year</p> | | | | |
| Ancillary Orders | | | | |
| <p>Anaphylaxis Kit</p> <p>If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <ul style="list-style-type: none"> ▪ Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN. ▪ Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement. ▪ 0.9% Sodium Chloride 500 mL (> 30 kg) or 250mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. ▪ Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis. | | | | |
| <p>Lab Orders</p> <p><input type="checkbox"/> No labs ordered at this time.</p> <p><input type="checkbox"/> Other: _____</p> | | | | |
| <p>Skilled nurse to assess and administer as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.</p> <p>If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy and skilled nursing plan of treatment will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.</p> | | | | |
| <p><i>I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.</i></p> | | | | |
| Prescriber Signature: _____ | | | | Date: _____ |
| Prescriber Information | | | | |
| Prescriber Name: | | Phone: | Fax: | |
| Address: | | NPI: | | |
| City, State: | Zip: | Office Contact: | | |
| Fax completed form, insurance information, and clinical documentation to: 713-983-4647 | | | | |
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