BENRALIZUMAB (FASENRA) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		

Phone:	Height:	☐ Inches ☐ cm	Weight:	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA OR (List):

BENRALIZUMAB (FASENRA) Medication Order

Severe Eosinophilic Asthma (or patients aged 6 years and older who weigh ≥35 kg):

☐ 30 mg SUBQ every 4 weeks for first 3 doses followed by once every 8 weeks thereafter

Severe Eosinophilic Asthma - Pediatric dosing (aged 6-11, <35 kg):

☐ 10 mg SUBQ every 4 weeks for first 3 doses followed by once every 8 weeks thereafter

Eosinophilic Granulomatosis with Polyangiitis (for patients 18 years and older):

☐ 30 mg SUBQ every 4 weeks for first 3 doses followed by once every 8 weeks thereafter

☐ Other: _____

Dispense refills x 1 year

Ancillary Orders

Anaphylaxis Kit

If this is a 1st dose, would you like Option Care Health to provide an anaphylaxis kit with the 1st dose?

☐ Yes ☐ No

- 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.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

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.

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.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

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

Not valid for use for patients residing in Arizona, New York, and Wisconsin

