

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

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