Infusion ASSOCIATES

Phone: 616-954-0600 Fax: 616-954-1675

Fasenra Injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

Does the patient currently use tobacco products? ☐ Yes ☐ No

What is the patient's peripheral blood eosinophil count? _____ cells/mcL; Date drawn: _____

Has the patient had 3 or more asthma exacerbations in the past year? ☐ No ☐ Yes please select all that apply:

☐ Oral steroids were required for at least 3 days
☐ Exacerbation resulted in an ED visit and/or hospitalization

Has patient been compliant on high dose ICS/LABA inhaler for at least 3 months? ☐ Yes ☐ No

Has the patient tried and failed Dupixent? ☐ Yes ☐ No

In the past 6 months, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

Fasenra (*benralizumab*) Subcutaneous Injection Dosage:

☐ 30 mg

☐ Other: _____

Frequency: ☐ **Every 4 weeks x 3 doses then once every 8 weeks thereafter.**
☐ **Every 8 weeks**

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____