



Phone: (833) 394-0600 Fax: (833) 996-4888

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

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

Drug	Dose	Dates of use

Fasenra (benralizumab) 30mg Subcutaneous Injection

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

Date of last injection if not at IA: _____ Expiration Date: ____/____/____

Printed Provider Name: _____

Provider Signature: _____

Office Phone Number: _____ Office Fax Number: _____

Contact Name: _____ Contact Phone Number: _____

New referring providers, how did you hear about us? Web Search Pharma Rep Drug Locator Patient Word of Mouth IA Clinical Liaison IA Website Facebook Instagram TV/streaming Other: _____