

Fasenra® (benralizumab) Referral Form



Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status:

New Referral

Updated Referral

Referral Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:	Patient Email:		
NKDA Allergies:	Weight (lbs/kg):	Height:	
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

NURSING

Infusion to be administered per Vivo protocols.

FASENRA THERAPY ADMINISTRATION

LABORATORY ORDERS

CBC	At each dose	Every _____
CMP	At each dose	Every _____
CRP	At each dose	Every _____
OTHER		

30 mg injection every 4 weeks for 3 doses, then every 8 weeks

30 mg injection every 8 weeks

Patient is dependent on oral corticosteroids

OTHER INFORMATION/ORDERS

REQUIRED DOCUMENTATION

Patient Demographics

Insurance Card/Information

Progress Notes Supporting DX

Current Medication List and H&P

Absolute Eosinophil Count (>300 in prior 12 months or >150 in prior 6 months)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print)	Provider Signature	Date
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Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 800-540-1852	New Jersey: 800-540-1852	Pennsylvania: 215-399-9244	