Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025 Waterside Rd, Suite 100B
Prince George, VA 23875

Physician Order - Fasenra (Benralizumab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:
Patient Weight: _____ kg or _____ lb	Patient Height: _____ in

REFERRAL STATUS

☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)

☐ Richmond ☐ Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD-10 CODE

☐ Severe persistant asthma, uncomplicated J45.50
☐ Severe persistant asthma w/ acute exacerbation J45.51
☐ Other: _____ ICD10 _____

Does your patient have blood eosinophil counts ≥ 300cells/μL within the past 12 months? ☐ Yes ☐ No

REQUIRED DOCUMENTATION (must include)

☐ This signed order form by the provider
☐ Patient Demographics AND Insurance Information
☐ Number of asthma exacerabtions in past 12 months
☐ Recent Pulmonary Function Tests - including FEV1 AND FEV1 reversibility
☐ Patient currently receiving same therapy at _____ Last dose: _____
☐ Clinical/Progress Notes
☐ Labs and Tests Supporting Primary Dx, including blood eosinophil counts

List Tried & Failed Therapies, including duration of treatment
1)
2)
3)

MEDICATION ORDERS

Initial Dosing ☐ Fasenra 30mg sub q every 4 weeks for three doses then every 8 weeks
Maintenance Dosing ☐ Fasenra 30mg sub q every 8 weeks

Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____

OPTIONAL PREMEDICATIONS and LAB ORDERS

☐ Acetaminophen 650mg PO prior to administration
☐ Diphenhydramine 25mg PO prior to administration
☐ CMP at each administration
☐ Other PreMed or Lab Order with frequency: _____

In the event of an infusion reaction or adverse event, our covering physician will be notified and appropriate medical care will be administered.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL required documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.