Fax your completed order to 877-734-1157

Patient Name: ______________________DOB: ____/___/________Date of Last Infusion: ______/___/________
Height___________Weight__________

Infusion Location: (state and site) ________________________________

Fasenra® (benralizumab) Orders

Diagnosis (please provide ICD-10 code in space provided):

_________Severe Persistent Asthma
(ICD-10)

_________Other: ______________________
(ICD-10)

Provider: Is patient required to carry epinephrine auto-injector?

- ❑ Yes, patient has been provided epinephrine auto-injector and has been educated on its use
- No, patient does not require epinephrine auto-injector

Nursing Orders:

-Hold Fasenra and notify provider if patient reports:

- Current parasitic infection
- New or worsening asthma symptoms since initiating Fasenra

-If indicated by provider above, confirm patient has epinephrine auto-injector and understands indications for use.

☐ Initial Dose: Fasenra 30mg sub-q every 4 weeks x 3 doses, then every 8 weeks

☐ Subsequent Dosing: Fasenra every 8 weeks

Observation Period Mandatory for all patients every visit. If patient refuses to stay, ROR form may be signed to waive observation period after ______________infusions:

-Monitor patient for post-injection observation period of 1 hour.

-Record vital signs prior to discharge.

-If patient develops bronchospasm, angioedema, hypotension, urticaria or other signs of anaphylaxis, initiate Hypersensitivity Reaction Management Protocol.

Frequency:

❑ Every ___________weeks

Additional Orders:

Provider Name (print): ____Date:________________

Provider Signature: ____Time: ________________

Order Reviewed 4/12/23. Order valid for one year unless otherwise indicated.