MIC | METRO INFUSION CENTER

MEDICATION ORDERS- FASENRA (BENRALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
☐ New Referral	☐ Dose or Frequency Change	☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Severe Eosinophilic Asthma	ICD 10 Code: J45.50
☐ Other: ______________________________	ICD 10 Code: _____________
Does your patient have blood eosinophil counts ≥ 300 cells/μL within past 12 months?	☐ YES ☐ NO

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts
☐ Pulmonary Function Tests	
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Initial Dosing	☐ Fasenra 30mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
Maintenance Dosing	☐ Fasenra 30mg SubQ every 8 weeks
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this form is strictly confidential and will become part of the patient's medical record.

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