# Fasenra (benralizumab)

MIC | METRO INFUSION CENTER

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

**Infusion Office Preference:** _____

| **PATIENT INFORMATION** | | | |
|---|---|---|---|
| Date: | Patient Name: | | DOB: |
| ☐ NKDA Allergies: | | Weight (lbs / kg): | Height: |
| Patient Status: ☐ New to Therapy ☐ Continuing Therapy - Last Treatment Date: | | | Next Due Date: |

| **PROVIDER INFORMATION** | | | |
|---|---|---|---|
| Office Contact Name: | Office Email: | | |
| Prescribing Providers Name: | Provider NPI: | | |
| Office Address: | City: | State: | Zip: |
| Office Phone Number: | Office Fax Number: | | |

**DIAGNOSIS AND ICD 10 CODE**

☐ Severe persistent asthma, uncomplicated ICD 10 Code: J45.50
☐ Severe persistent asthma with (acute) exacerbation ICD 10 Code: J45.51
☐ Eosinophilic asthma ICD 10 Code: J82.83
☐ Other: _____ ICD 10 Code _____

➔ **Does your patient have blood eosinophil counts ≥ 300 cells/µL within past 12 months?**
**☐ No ☐ Yes- provide results**

☐ Polyarteritis with lung involvement [EGPA/Churg-Strauss] ICD 10 Code: M30.1
☐ Other: _____ ICD 10 Code _____

**REQUIRED DOCUMENTATION/Testing**

| | |
|---|---|
| ☐ This signed order form by the provider<br>☐ Patient demographics AND insurance info<br>☐ Clinical/Progress notes supporting primary dx | ☐ Clinical/Progress notes<br>☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts |

List Tried & Failed Therapies 1) 2)

**MEDICATION ORDERS**

| **Severe Asthma/Eosinophilic asthma** | |
|---|---|
| Initial Dosing | ☐ Fasenra 30mg SQ every 4 weeks for three doses then every 8 weeks thereafter |
| Maintenance Dosing | ☐ Fasenra 30mg SQ every 8 weeks |
| **Polyarteritis with lung involvement [EGPA/Churg-Strauss]** | |
| ☐ Fasenra 30 mg SQ every 4 weeks | |

Refills*: ☐ None ☐ X6 months ☐ X1 year ☐ Other: _____
**(if not indicated order will expire one year from date signed)*

**Provider Name (Print)** **Physician Signature:** **Date:**

**Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com**

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

Revised 6/9/25