**Nevada Infusion**
**5401 Longley Lane, Suite 34, Reno, NV 89511**
**PH: 775-453-0667 | Fax: 775-470-8478**

# Fasenra Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

**DIAGNOSIS:**

- ☐ Severe persistent asthma, uncomplicated ICD-10 code: J45.50
- ☐ Severe persistent asthma with acute exacerbation ICD-10 code: J45.51
- ☐ Other: _____ ICD-10 code: _____

**ORDER FOR FASENRA (BENRALIZUMAB):**

- ☐ **Initial Dose:** 30mg subcutaneously every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter x 1 year
- ☐ **Maintenance Dose:** 30mg subcutaneously every 8 weeks x 1 year

**PRE-MEDICATIONS:**

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

**MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:**

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

**PROVIDER INFORMATION:**

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

**Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478**

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

**Please Include Required Documentation for Expedited Order Processing & Insurance Approval:**

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

☐ Please indicate any tried and failed therapies:

- ☐ Inhaled corticosteroids _____
- ☐ Long-acting beta 2 agonist _____
- ☐ Long-acting muscarinic antagonist _____
- ☐ Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period?
  - ☐ Yes OR ☐ No
- ☐ Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120?
  - ☐ Yes OR ☐ No

**Additional REQUIRED Information:**

☐ Include labs and/or test results to support diagnosis

☐ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks?
- ☐ Yes OR ☐ No (please attach CBC results)

☐ FEV1 score: _____

☐ Is the patient or caregiver able to administer Fasenra for self-administration?
- ☐ Yes OR ☐ No

If no, please state reason: _____

☐ Other medical necessity: _____

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