

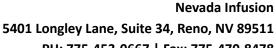


## **Fasenra Order Form**

Patient Nar	me:			DOB:		
Sex:	Height:	Weight:		Allergies:		
DIAGNOSIS	<b>5</b> :					
☐ Sev	ere persistent asthma,	uncomplicated ICD-	10 code: J45	.50		
☐ Sev	ere persistent asthma v	vith acute exacerba	tion ICD-10 c	ode: J45.51		
☐ Oth	Other: ICD-10 code:					
ORDER FOI	R FASENRA (BENRALIZU	IMAR):				
	•	•	eeks for the f	irst 3 doses followed by once every 8 weeks		
	reafter x 1 year	, ,		,		
☐ Mai	intenance Dose: 30mg	subcutaneously eve	ery 8 weeks x	1 year		
DDF 145D16						
PRE-MEDIC	_	O DO				
	Acetaminophen 65	•	rtos 10 ma F	00		
	☐ Diphenhydramine 2☐ Hydrocortisone 100	•	_			
	☐ Additional Pre-Med			_		
	- Additional FTE-INIEC					
MAY ADMI	NISTER IF NEEDED FOR	RALLERGIC REACTIO	ON:			
	ada Infusion Hypersen					
	er:	<del>-</del>				
	ripheral IV, Port, Midlir	•				
	10 mls NS pre/post inf	usion OR Heparin 5	5ml for port -	- 100 units/ml		
NURSING:	Per Nevada Infusion					
LABS ORDE	RS:		F.	ax results to:		
PROVIDER	INFORMATION:					
	lame:					
				Date:		
Point of Co	ntact:	Pho	ne:	Email:		

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

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



DOB:



•	PH: 775-453-0667   Fax: 775-4

Patient Name:

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
$\square$ 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
$\Box$ Does patient have a baseline peripheral blood eosinophil level of ≥ 150 cells/mcL within the past 6 weeks? $\Box$ Yes OR $\Box$ No (please attach CBC results)
☐ FEV1 score:
$\square$ 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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