INTRAMED Plus
infusion services

FASENRA®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnsosis):

Primary Diagnosis: _____Severe persistent asthma, uncomplicated ICD-10 Code: J.45.50 _____
_____Severe persistent asthma with acute exacerbation ICD-10 Code: J45.51_____
_____Other: _____ ICD-10 Code: _____

3. Allergies:_____(or attach list)

Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
  Including pulmonary function tests and CBC with diff
- Previous Drug Therapy History, including therapies trialed/failed and date of last administration:
  ❑ Xolair ❑ Cinquair ❑ Nucala Date:_____ Desired Washout Period: _____weeks

Patient
Weight: _____ lbs.
Height:_____ in.

FASENRA® (benralizumab)

4. Drug Order:

Fasenra 30 mg

❑ **Induction Dose:** _____# Refills (Recommend 4)
Administer 30 mg subcutaneously every 4 weeks for 3 doses and then every 8 weeks therafter

❑ **Maintenance Dose:** _____# Refills (Recommend 3)
Administer 30 mg subcutaneously every 8 weeks

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337