

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 diagnosis):**

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 thereafter

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 CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
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