Benralizumab (Fasenra)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Severe Persistent Asthma:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☑ Administer Fasenra 30mg subcutaneously

☑ One-hour post-injection observation period mandatory for all patients every visit unless waived by referring provider.

FREQUENCY *(Choose one)*

☐ Induction: week 0, 4, 8, and then every 8 weeks

☐ Maintenance: every 8 weeks

☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- current parasitic infection
- new or worsening asthma symptoms since initiating Fasenra

☑ If indicated as required by provider, confirm patient has epinephrine auto-injector and understands indications for use.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with steroids, FEV1 level, exacerbations/flares in 12 months, hospitalizations in 12 months, FVC, Percent of body area covered for atopic dermatitis and eosinophil levels.

Required Labs: Eosinophil levels, CRP/ESR

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested. .