Benralizumab (Fasenra) Order Form

SOMC Cancer Center & Infusion
Ph: (740) 356-7490
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PATIENT & PRESCRIBER INFORMATION

Patient Name: ________________________________ DOB: _____________ Phone: (H) __________________ (C) __________________

Patient Address: ____

Ht.: _______ Wt.: _______ ☐lbs. ☐kg. Allergies: ____

Prescriber Name/Title: __________________________________ Address: ____

Phone: _______________________ Fax: _______________________ Prescriber NPI #: ____

REQUIRED: **Most Recent H&P, clinical notes, & medication list are required unless the patient is established with SOMC. Supporting clinical notes should include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

LAB RESULTS: **Include verification of eosinophil count from CBC.**

DIAGNOSIS, CLINICAL INFORMATION, & PRESCRIPTION

☒ **In the event of an adverse reaction, line maintenance/flushes, or O2 are required, the SOMC AIC established protocols will be utilized.**

☒ **Monitor for any adverse events post administration for at least 30 minutes or until clinically stable.**

AND

Diagnosis (Check all that apply)

☐ Severe Persistent Asthma, Uncomplicated **and** Eosinophilic Asthma

Initial Dose:

☐ **Benralizumab (Fasenra) 30 mg, subcutaneous, every 4 weeks, X 3 doses; then every 8 weeks X 1 year**

Maintenance Dose:

☐ **Benralizumab (Fasenra) 30 mg, subcutaneous, every 8 weeks, X 1 year**

PROVIDER:	DATE:	TIME:	SIGNATURE: