FASENRA®Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name:_____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact:_____ Phone Number: _____

Primary Diagnosis:

_____ Severe persistent asthma, uncomplicated
_____ Severe persistent asthma with acute exacerbation
_____Other: _____

Please attach the following: 1. Clinical MD Notes, labs, test supporting primary diagnosis, Including pulmonary function tests and CBC with diff. 2. Previous Drug Therapy History, including therapies trialled/failed and date of last administration: Xolair ◯ Cinquair ◯ Nucala ◯ Date:_____ Desired Washout Period: _____weeks, 3. Copy of the patient's Insurance Card

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **FASENRA® (benralizumab)**
Fasenra 30 mg

☐ ***New Start:*** _____ # Refills (Recommend 4 Refills)

Administer 30 mg subcutaneously every 4 weeks for 3 doses and then every 8 weeks therafter

☐ ***Maintenance Dose:*** _____ # Refills (Recommend 3 Refills)

Administer 30 mg subcutaneously every 8 weeks

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

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date