NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-307-2244
Phone: 405-515-2470

ORD

Benralizumab (Fasenra)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

** Include documentation of eosinophilic phenotype defined as blood eosinophils GREATER THAN or EQUAL to 150 cells/microliter within 6 weeks of first dose AND documentation of add on maintenance treatment in patients regularly receiving BOTH medium to high dose inhaled corticosteroids AND an additional controller medication such as long acting beta agonist.***

Diagnosis Code/Description for treatment:

☐ Severe Persistant asthma, uncomplicated (J45.50)
☐ Severe Persistant asthma with acute exacerbation (J45.51)

Benralizumab (Fasenra) [J0517 : 1 MG = 1 unit]

Initial Dose

☑ Benralizumab (Fasenra) 30 MG SUBCUTANEOUSELY ONCE EVERY 4 WEEKS x 3 doses, followed by maintenance dose.

Maintenance Dose – Starts 8 weeks after last initial dose given.

☑ Benralizumab (Fasenra) 30 MG SUBCUTANEOUSELY ONCE EVERY 8 WEEKS

Discharge

☑ Discharge home after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____

_____
PHYSICIAN'S SIGNATURE

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