MIC | METRO INFUSION CENTER

MEDICATION ORDERS- FASENRA (BENRALIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
☐ Severe Eosinophilic Asthma ICD 10 Code: J45.50
☐ Other: _____ ICD 10 Code: _____
Does your patient have blood eosinophil counts ≥ 300 cells/µL within past 12 months? ☐ YES ☐ NO

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ Pulmonary Function Tests	☐ Clinical/Progress notes ☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Initial Dosing	☐ Fasenra 30mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
Maintenance Dosing	☐ Fasenra 30mg SubQ every 8 weeks
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164