

Fasenra Order Form

Pre-filled order form for Fasenra (benralizumab) — Eosinophil-depleting therapy for severe asthma

REFERRING PROVIDER

PROVIDER NAME	NPI	DEA (IF CONTROLLED)	SPECIALTY
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PRACTICE / CLINIC NAME	OFFICE PHONE	OFFICE FAX
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OFFICE CONTACT NAME	CONTACT PHONE	CONTACT EMAIL
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PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL
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DATE OF BIRTH	SEX	PATIENT PHONE	BEST TIME TO CONTACT
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ADDRESS	CITY, STATE, ZIP
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INSURANCE

PRIMARY INSURANCE	MEMBER ID	GROUP #
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SECONDARY INSURANCE (IF ANY)	MEMBER ID	GROUP #
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DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS	ICD-10 CODE
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SECONDARY DIAGNOSIS (IF APPLICABLE)	ICD-10 CODE
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Common indications for this medication: *Severe eosinophilic asthma, Eosinophilic granulomatosis with polyangiitis (EGPA)*

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

FASENRA REFERENCE

Generic name: benralizumab
Specialty: Pulmonology & Allergy
Typical infusion time: Brief administration
Typical schedule: Loading every 4 weeks (3 doses), then every 8 weeks

MEDICATION ORDER

MEDICATION (DEFAULT: FASENRA)	GENERIC / ALT (BENRALIZUMAB)	STRENGTH / FORMULATION
DOSE	FREQUENCY (TYPICAL: LOADING EVERY 4 WEEKS (3 DOSES), THEN EVERY 8 WEEKS)	DURATION (TYPICAL: BRIEF ADMINISTRATION)

ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)
		BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Arbor to verify before each infusion:

- | | | |
|--|--|---|
| <input type="checkbox"/> CBC w/ differential | <input type="checkbox"/> CMP | <input type="checkbox"/> Liver function panel |
| <input type="checkbox"/> Hepatitis B/C panel | <input type="checkbox"/> TB screen (T-SPOT or QFT) | <input type="checkbox"/> Pregnancy test (urine) |
| <input type="checkbox"/> Iron studies (ferritin, TSAT) | <input type="checkbox"/> Vitamin levels (B12, D, folate) | <input type="checkbox"/> Other (specify below) |

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Arbor Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE	PRINTED NAME	DATE



Form code: ARB-ORDER-FASENRA · Submit to Arbor Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Arbor will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@arborinfuse.com