Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Fasenra® (benralizumab) Pediatric Standard Plan of Treatment for Asthma

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	J45.50 - Severe persistent asthma, uncomplicated	☐	J45.52 - Severe persistent asthma with status asthmaticus
☐	J45.51 - Severe persistent asthma with acute exacerbation	☐	J82.00 - Pulmonary eosinophilia, not elsewhere classified
☐	J82.83 - Eosinophilic Asthma		
☐	_____ - Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	Blood Eosinophil Level (CBC)		☐ **Continue current order until insurance approved**
6	Lab results/Pulmonary function test to support diagnosis (ex: FEV1 score)		

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

Provider Attestation for HCP administration:

☐ Provider attestation that the patient or caregiver are not competent or are physically unable to administer the Fasenra product FDA labeled for self-administration

☐ Patient has a history of uncontrolled disease and ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

☐ The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.

☐ Patient has experienced severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Fasenra within the past 6 months and requires administration and direct monitoring by a healthcare professional*

☐ Due to patient's weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of requested drug

*Specific reactions: _____

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive Fasenra™ (benralizumab) if patient has signs/symptoms of parasitic infection, is currently being treated for a parasitic infection, or is having acute bronchospasm and/or asthma attack.

DOSE/FREQUENCY FOR PEDIATRIC PATIENTS 6 TO 11 YEARS OF AGE WEIGHING LESS THAN 35KG:

☐ **Induction**: Fasenra™ (benralizumab) 10 mg/0.5 mL subcutaneous injection every 4 weeks for the first (3) doses given at week 0, week 4, week 8

☐ **Maintenance**: Fasenra™ (benralizumab) 10 mg/0.5 mL subcutaneous injection every 8 weeks

If the patient is 6 to 11 years of age weighing more than 35kg, or 12 years of age or older, refer to the standard Fasenra POT for dosing.

SPECIAL ORDERS:

☐ _____

Extended post treatment monitoring for any patient new to therapy: monitor patient for one (1) hour after first injection, for 30- minutes after second injection, and then 15-minutes for all subsequent injections.

☑ Refills x 12 months unless noted otherwise here:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	