NPI#_____
DEA#_____

FAX ORDERS: 702-697-2107

LifeCare

(benralizumab)

FASENRA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Eosinophilic asthma

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

FASENRA ORDERS

DOSAGE

○ Initial dose 30 mg every 4 weeks for the first 3 doses, then every 8 weeks
○ Maintenance dose: 30 mg every 8 weeks
○ _____ *(other frequency)*

PATIENT WEIGHT

_____lbs.
_____kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

*Address:*_____ _____