Fasenra (benralizumab)

Provider Order Form rev. 5/20/2022

AleraCare
A Healthcare Solutions Company
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PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ J45.50 Severe, persistent asthma

☐ Other:_____

MEDICATION ORDER

Fasenra (benralizumab)

Dose:

☐ 30mg SC

Frequency:

☐ every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

☐ every 8 weeks

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**