

Benralizumab (Fasenra)

Provider Order Form rev. 9/07/26



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Mobile Phone Number: _____

Weight (lbs/kg): ☐ NKDA Allergies: _____

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• Eosinophil Count • PFT

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J82.83 Eosinophilic Asthma

☐ J45.51 Severe persistent asthma with (acute) exacerbation ☐ M30.1 Polyarteritis with lung involvement [EGPA/Churg-Strauss]

☐ Other: _____

PRIMARY MEDICATION ORDER

Benralizumab (Fasenra), subcutaneous injection

☐ Patient is required to stay for 30-minute observation

• Refill for 12 months unless otherwise noted: _____

☐ **New Start:** 30mg subcutaneous Injection at week 0, 4, 8, and every 8 weeks thereafter

☐ **Maintenance:** 30mg subcutaneous Injection every 8 weeks

PRE-MEDICATION

Note: pre-meds not typically indicated for Fasenra

☐ Other: _____

Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print) _____ Provider Signature _____ Provider NPI _____ Date _____

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772