McLeod Health

Place Sticker Here

Benralizumab (Fasenra) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one):

☐ J45.50 Severe persistent asthma, unspecified

☐ J45.51 Severe persistent asthma with (acute) exacerbation

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

- Benralizumab (Fasenra) (J0517) 30 mg via subcutaneous injection
- Frequency: ☐ Induction: Weeks 0, 4, and 8 then every 8 weeks thereafter
  ☐ Maintenance: every 8 weeks
  ☐ Other: _____
- Order Duration: Six months unless otherwise specified (Other: _____)

Standing Orders:

- Monitor patient for 30 minutes following each injection.
- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion/injection will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Provide blood eosinophil level prior to start of therapy

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received benralizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)