INTRAMED Plus
infusion services

FASENRA®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
   Patient Name   **DOB**   **Patient Phone/Cell #**

   Patient demographic and insurance information to be faxed with Infusion Order Form

2. **Medical Information (Please complete/select appropriate diagnsosis):**

   Primary Diagnosis: _____Severe persistent asthma, uncomplicated   ICD-10 Code: J.45.50 _____
                        _____Severe persistent asthma with acute exacerbation ICD-10 Code: J45.51_____
                        _____Other: _____   ICD-10 Code: _____

3. Allergies:_____(or attach list)

Patient
Weight: _____ lbs.
Height:_____ in.

   Clinical Information – Please fax with Infusion Order Form:

   • Clinical notes & labs supporting primary diagnosis
      Including pulmonary function tests and CBC with diff

   • Previous Drug Therapy History, including therapies trialed/failed and date of last administration:
      ❏ Xolair   ❏ Cinquair   ❏ Nucala   Date:_____   Desired Washout Period: _____weeks

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FASENRA® (benralizumab)

4. **Drug Order:**

Fasenra 30 mg

   ❏ **Induction Dose:**   Doses Authorized: 3 doses

   Administer 30 mg subcutaneously every 4 weeks for 3 doses and then every 8 weeks therafter

   ❏ **Maintenance Dose:**   Doses Authorized: 5 doses

   Administer 30 mg subcutaneously every 8 weeks

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. **Physician Signature:** _____ / _____ Date: _____
                        Dispense as written   Substitution permitted

   Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	**CENTRAL INTAKE PHONE**
CENTRAL FAX 803.999.1754	**803.999.1750**