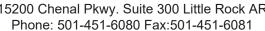




**Physician Signature:



FASENRA (BENRALIZUMAB) **INFUSION ORDERS**

REQUIRED INFORMATION		
☐ This signed order form from the provider ☐ Patient demographics & insurance information ☐ Clinical/Progress Notes, Labs & Tests supporting primary diagnosis (ICD-10 below)		
Patient Name:	DOB:	
Allergies:	Patient Phone:	
Diagnosis:		
☐ Severe Asthma with eosinophilic phenotype (ICD-1	0:)	
□ Other: (ICD-1	0:)	
Pt. Weight kg Allergies:		_
FASEN	IRA ORDERS	
Fasenra ☐ Initial Dose: 30mg subcutaneously every 4 wee ☐ Maintenance Dose: 30mg subcutaneously ever	-	nce every 8 weeks thereafter
Additional Instructions:		
Physician Name:	Phone:	Fax:

Date: