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New Rochelle, NY
10801

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(benralizumab)

# FASENRA infusion orders

Patient Name ______________________________ DOB ____________

Phone ______________________________ M ◯ F ◯

## DIAGNOSIS *Please provide ICD-10 code*

- ☐ _______ Eosinophilic asthma
- ☐ _______ ____________________ *(other)*

## PRE-MEDICATION

- ☐ Tylenol 1000mg IV
- ☐ Cetirizine 10mg IV
- ☐ Diphenhydramine 25mg IV
- ☐ ______________________
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ ______________________

*(other)*

## FASENRA ORDERS

### DOSAGE

- ◯ Initial dose 30 mg every 4 weeks for the first 3 doses, then every 8 weeks
- ◯ Maintenance dose: 30 mg every 8 weeks
- ◯ ______________________ *(other frequency)*

### PATIENT WEIGHT

________ lbs.

________ kg

## NOTES

______________________________________________

## ORDERING PROVIDER

Signature **X** ______________________________ Date ____________

Provider ______________________ Phone __________ Fax __________

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