

FASENRA ORDER FORM

Date: _____	ICD-10 Code: _____
Patient Name: _____	Allergies: _____
Date of Birth: _____	Weight: _____ lbs OR _____ kg
Therapy Status	Provider Information
<input type="checkbox"/> New Start <input type="checkbox"/> Continuing Therapy: Last Dose: _____	Ordering Provider: _____ Provider NPI: _____ Provider Phone: _____ Provider Fax: _____ Provider Address: _____

MEDICATION ORDER

<input type="checkbox"/> Fasenra	<input type="checkbox"/> Fasenra 30mg SQ every four weeks x three doses, followed by Fasenra 30mg SQ every eight weeks per protocol. <input type="checkbox"/> Fasenra 30mg SQ every eight weeks per protocol.	<i>Refills x one year from date of signature unless indicated below.</i> <input type="checkbox"/> _____ Refills
----------------------------------	--	--

PRE-MEDICATIONS

<input type="checkbox"/> Acetaminophen: _____ ^{Oral} 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10 mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: _____ 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other _____	<input type="checkbox"/> Dexamethasone: _____ ^{IV} 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: _____ 25mg _____ 50mg <input type="checkbox"/> Famotidine: _____ 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone 125mg <input type="checkbox"/> Hydrocortisone 100mg <input type="checkbox"/> Ondansetron: _____ 4mg _____ 8mg <input type="checkbox"/> Other _____
---	---

LAB ORDERS (Please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering, and monitoring is the responsibility of the prescriber	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List • Recent Lab Work
---	---

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Dispense as Written: _____ Prescriber Name	Substitution Allowed: _____ Prescriber Name
_____ Date	_____ Date