FASENRA (BENRALIZUMAB) INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:	ZIP:	
Phone:	Email:	Height:	□ inches □ cm	Weight:	□ lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:	ZIP:	
NPI #:	DEA#:			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Fasenra (benralizumab)	□ 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks therafter □ 30mg subcutaneously every 8 weeks □ Other: _____	□ x 1 year □ _____

Other orders: _____

Lab Orders: _____ Lab frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution. □ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature: X **Date:**

COMPREHENSIVE SUPPORT FOR FASENRA (BENRALIZUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

- □ Include signed and completed order (MD/prescriber to complete page 1)
- □ Include patient demographic information and insurance information
- □ Include patient's medication list
- □ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - □Please indicate any tried and failed therapies:
    - □Inhaled corticosteroids _____
    - □Long acting beta 2 agonist _____
    - □Long acting muscarinic antagonist _____
  - □Does the patient have a history of 2 exacerbations requiring a course of oral/ systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period? □ Yes □ No
  - □Doesthe patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120? □ Yes □ No
- □ Includelabs and/or test results to support diagnosis
  - □ Doespatient have a baseline peripheral blood eosinophil level of ⩾ 150 cells/mcL within the past 6 weeks? □ Yes □ No **(attach CBC)**
  - □ FEV1score: _____
- □ Isthepatient or caregiver able to administer Fasenra for self-administration?
  - □ Yes□ No If no, please state reason: _____
- □ Othermedical necessity: _____