(benralizumab)

FASENRA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Eosinophilic asthma

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Cetirizine 10mg PO

☐ Diphenhydramine 25mg PO

☐ _____

☐ 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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