(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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