Fasenra Injection Order

Fax 888 511-7654   Phone 888 864-7341

Patient Name: ______________________________ **DOB:** ______________________

Patient Phone: ______________________________ **SEX:** **M** **F**

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: J45.50 Severe persistent asthma

Other _______________

ICD-10 ____________________

Patients weight: _________

Lab Date: ____________________

Allergies: ____________________

ALSO INCLUDE...

Clinical/ Progress Notes

Demographics Sheet

Current Medications

Labs

FASENRA ORDER

Fasenra Dose: 30mg/ml single dose prefilled syringe

Frequency: Every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

Pre-treatment EOS serum: __________cells/uL

Date of last Fasenra Injection: ________________

*** **NOTE:** Patient **must have** an EpiPen/ epinephrine in their possession at each appointment date.***

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: ____________________________ **Phone:** ____________________

Practice Address: ____

Office Contact: ________________________________ **Fax:** ____________________

NPI/ TIN: ______________________

Referring Physician's Signature_________________________________ **Date:** __________