vitalcare of SAN ANGELO

601 S. Main St., Suite 110, Keller, TX 76248
P / 682.357.4040 • Fax: 682-357-4042
www.vitalcarenorthtexas.com

FASENRA (BENRALIZUMAB) INFUSION ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis (ICD-10 below)

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Severe Asthma with eosinophilic phenotype (ICD-10: _____)

☐ Other:_____ (ICD-10: _____)

Pt. Weight _____ kg Allergies:_____

FASENRA ORDERS

Fasenra ☐ Initial Dose: 30mg subcutaneously every 4 weeks for the first 3 doses followed by once every 8 weeks thereafter

☐ Maintenance Dose: 30mg subcutaneously every 8 weeks

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	