Fasenra® (benralizumab) Referral Form

Patient Preferred Clinic (select one): _____

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☐ CBC ☐ At each dose ☐ Every _____
☐ CMP ☐ At each dose ☐ Every _____
☐ CRP ☐ At each dose ☐ Every _____
☐ OTHER

OTHER INFORMATION/ORDERS

FASENRA THERAPY ADMINISTRATION

☐ 30 mg injection every 4 weeks for 3 doses, then every 8 weeks

☐ 30 mg injection every 8 weeks

☐ Patient is dependent on oral corticosteroids

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Absolute Eosinophil Count** (>300 in prior 12 months or >150 in prior 6 months)

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Fax Numbers

☐ Virginia: 804-500-5941
☐ Colorado: 303-418-4679
☐ Florida: 904-930-4211
☐ Texas: 469-340-0044
☐ Nevada: 702-489-5744
☐ New Jersey: 609-955-3711
☐ Ohio: 216-400-0674
☐ Oklahoma: 918-770-4421
☐ Massachusetts: 800-540-1852
☐ Pennsylvania: 215-399-9244
☐ New York: 800-540-1852
☐ Connecticut: 203-724-4838

Have a Question? (720) 902-4111
Email Referrals To: referrals@vivoinfusion.com
Email Specialty Referrals to:
info@specialtyinfusion.com

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