

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

- | | | | | |
|---------------------|-----------------------|-------------------------|---------------------|--------------------|
| 1. Insurance Card | 2. History & Physical | 3. Patient Demographics | 4. Most Recent Labs | 5. Medication List |
| 6. Eosinophil Count | 7. PFT | | | |

PRIMARY DIAGNOSIS

- J45.40 Moderate persistent asthma, uncomplicated J45.50 Severe persistent asthma, uncomplicated
 J45.51 Severe persistent asthma with (acute) exacerbation J45.901 Unspecified asthma with (acute) exacerbation
 Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: There are no recommended standard pre-meds for Fasenra
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Fasenra IV
 Fasenra 30mg SubQ Injection at week 0, 4, 8, and every 8 weeks thereafter. Other _____
 FIRST DOSE?: Yes No Refill x12 months unless otherwise noted.

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____