



FASENRA (BENRALIZUMAB) Order Form

PHONE 515.225.2930 | FAX 515.559.2495

Patient Information Demographics Attached

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: Please attach a copy of insurance cards (front and back).

Medical Information

Diagnosis: Severe allergic asthma with eosinophilic phenotype ICD-10 Code: _____
Other: _____ ICD-10 Code: _____

Patient Weight: _____ lbs.

Allergies: _____

Clinical/progress notes, labs, and tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: Infusion Clinic Referring Physician

Lab Orders: _____

Fasenra Orders

FASENRA Initial dose: 30 mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter
Maintenance dose: 30 mg subcutaneously every 8 weeks

Additional Orders/Comments:

Physician Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Provider Name: _____ Signature: _____ Date: _____

Provider NPI: _____ Phone: _____ Fax: _____ Contact Person: _____

Service Areas

Des Moines, IA West Des Moines, IA Chicago, IL Omaha, NE Buffalo, NY Dallas, TX
Phoenix, AZ Other _____

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