Hy-Vee health
INFUSION CARE

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 __________

HY-VEEHEALTHINFUSION.COM

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