

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ lbs kg

Allergies: _____ NKDA

Patient status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation
- J82.83 Eosinophilic asthma
- Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

THERAPY ADMINISTRATION

Medication	Dose	Frequency
<input checked="" type="checkbox"/> FASENRA (Benralizumab), Subcutaneous Injection	<input checked="" type="checkbox"/> 30 mg	<input type="checkbox"/> every 4 weeks for 3 doses followed by every 8 weeks
		<input type="checkbox"/> every 8 weeks

Refills Zero 12 months _____ Order valid for 1 year unless otherwise stated. _____

Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

- Patient Demographics Insurance card Progress Notes supporting DX

Provider Signature _____ Date _____