O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Fasenra (Benralizumab) Injection

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal
Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION		
Date: Patient Name:		DOB:
☐ NKDA Allergies:		Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:
PROVIDER INFORMATION		
Office Contact Name:	Office Email:	
Prescribing Providers Name:	Provider NPI:	
Office Address:	City: State:	Zip:
Office Phone Number:	Office Fax Number:	

DIAGNOSIS AND ICD 10 CODE	**REQUIRED DOCUMENTATION**
☐ Severe Eosinophilic Asthma ICD 10 Code: J45.50 ☐ Other: _____ ICD 10 Code: _____ Does your patient have blood eosinophil counts less than 300 cells/µL within the past 12 months? Yes No	☐ This signed order form by the provider ☐ Patient demographics AND insurance information (copy of cards) ☐ Clinical/Progress notes ☐ Lab and Tests supporting primary diagnosis, including blood eosinophil counts ☐ Pulmonary Function Tests

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)	
Initial Dosing	☐ Fasenra 30mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
Maintenance Dosing	☐ Fasenra 30mg SubQ every 8 weeks
Refills	☐ X6 months ☐ X1 year _____ doses

_____

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

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.