

FASENRA (benralizumab) Referral Order Form



WWW.PACEINFUSION.COM

PH: 330-625-4900

F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change
(New Order Rqd.) ☐ Verify Benefits Only ☐ D/C Infusions
*indicate name of drug(s)

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

Office Contact: _____

Phone # & Ext.: _____ Fax #: _____

Direct Message _____

Address _____

FASENRA MEDICATION ORDERS

Dose: ☐ 30mg/ml single dose prefilled syringe

Frequency: Every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

INDICATION/DIAGNOSIS

- ☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with acute exacerbation
☐ Other _____

NOTES (ADDITIONAL INFO)

*ICD-10 _____ required

Ordering Provider's Signature

Date

REQUIRED DOCUMENTATION

- ☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
(w/in past 6 months)
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

PLEASE ATTACH THE FOLLOWING REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

- ☐ Eosinophils

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY

04/2020