



A Carelon Company

# FASENRA (BENRALIZUMAB) INJECTION ORDERS

**P:** 877-365-5566 | **F:** 855-889-2946

**PATIENT INFORMATION** Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies: \_\_\_\_\_

**Diagnosis Code ICD-10 (required):** \_\_\_\_\_ **Diagnosis Description:** \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Next Treatment Date: \_\_\_\_\_

**PHYSICIAN INFORMATION**

Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA#: \_\_\_\_\_ Tax ID: \_\_\_\_\_

**INSURANCE INFORMATION (or attach copy of cards)**

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**PRESCRIPTION INFORMATION (or attach a copy of the prescription)**

Drug	Dosing	Refills
Fasenra (benralizumab)	<input type="checkbox"/> 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter <input type="checkbox"/> 30mg subcutaneously every 8 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: \_\_\_\_\_

Lab Orders: \_\_\_\_\_ Lab frequency: \_\_\_\_\_

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

**PRESCRIBER SIGNATURE** By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X**

**Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Name:

DOB:

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - Please indicate any tried and failed therapies:
    - Inhaled corticosteroids \_\_\_\_\_
    - Long acting beta 2 agonist \_\_\_\_\_
    - Long acting muscarinic antagonist \_\_\_\_\_
  - Does the patient have a history of 2 exacerbations requiring a course of oral/systemic corticosteroids, hospitalization or an emergency room visit within a 12-month period?     Yes  No
  - Does the patient have an ACQ score consistently greater than 1.5 or ACT score consistently less than 120?     Yes  No
- Include labs and/or test results to support diagnosis
  - Does patient have a baseline peripheral blood eosinophil level of  $\geq 150$  cells/mcL within the past 6 weeks?     Yes  No    **(attach CBC)**
  - FEV1 score: \_\_\_\_\_
- Is the patient or caregiver able to administer Fasenra for self-administration?
  - Yes  No    If no, please state reason: \_\_\_\_\_
- Other medical necessity: \_\_\_\_\_