ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Benralizumab (Fasenra):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:	**ICD -10 Code:**
❑ Severe persistent asthma	❑ J45.50
❑ Pulmonary Eosinophilia	❑ J 82
❑ Other_____	❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

- Absolute eosinophilic count > 0.015 K/ul in prior 6 weeks OR absolute eosinophilic count > 0.03K/ul in prior 12 months

Treatment Regimen:
Benralizumab (Fasenra) Given SQ:
❑ 30mg SQ every 4 weeks for initial 3 doses followed by 30mg every 8 weeks
❑ 30mg every 8 weeks

☑ **Vital Signs:** Check vital signs prior to and after injection.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

☑ **Special Instructions:** If stable 30 minutes post injection, may discharge home. If no injection-related events with previous 3 doses may waive post-injection monitoring period and discharge patient home after completion.

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare Hypersensitivity guideline for treatment/management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time
_____	_____	_____	_____

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
Benralizumab (Fasenra)

MultiCare

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