Email: intake@infuseone.com | Phone: 1-800-581-0645 |
Please refer to website www.infuseone.com for location specific fax numbers

INFUSE ONE

(benralizumab)

FASENRA infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Eosinophilic asthma
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ _____

- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

FASENRA ORDERS

DOSAGE

- Initial dose 30 mg every 4 weeks for the first 3 doses, then every 8 weeks
- Maintenance dose: 30 mg every 8 weeks
- _____ *(other frequency)*

PATIENT WEIGHT

_____lbs.

_____kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____