ADVANCED PHARMACY SOLUTIONS

FASENRA REFERRAL FORM

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Today's Date ________________
Date Needed ________________

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ APS Pharmacy

Patient Name____ Date of Birth________________ ☐ Male ☐ Female

Address______________________________ Apt #________ City____________________ State________ Zip__________

Telephone____________________ Cell____________________ SSN____________________ Email______________________________

Allergies______________________________________ Comorbidities______________________________________

Current Medications (including OTC, if necessary, please fax a complete list)______________________________________

Primary Insurance______________________________ ID#____________________ Group #____________________

Secondary Insurance ______________________________ ID# ____________________ Group # ____________________

Insured's Name ______________________________ Employer ______________________________

City ____________________ State _______ Phone ____________________ **Please attach patient's insurance cards, front and back**

Diagnosis ICD-10 Code: J45.50 Severe persistent asthma, uncomplicated J45.51 Severe persistent asthma with (acute) exacerbation
Other ____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: ________________Cells/μL Date of test:_____/______/_______

Number of asthma exacerbations (requiring use of systemic corticosteroids and/or hospitalization) in last 12 months: ________________

PRESCRIPTION **PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS (Front and Back)**

Medication	Directions	Quantity	Refills
Fasenra™ (benralizumab)	**Initiation Dose:** 30 mg/mL solution in single-dose syringe administered subcutaneously once every 4 weeks for first 3 doses	1 ______	1 2 3 4
	Maintenance Dose: 30 mg/mL solution in single-dose syringe administered subcutaneously once every 8 weeks	1 ______	______ # Refills

Administration Method (choose one): Prefilled Syringe (Office-Administered) Pen (Self-Administered)

Has the patient been started on samples? **Yes** **No**

Total number of FASENRA (benralizumab) doses received since start date: _________ Date of last injection/treatment:_________

Please attach the following: Most Recent Progress Notes & Lab Results & Medication List

Thank you!

Prescriber's Name / Practice ______________________________ Office Contact______________________________

Address______________________________ Suite#______ City______________ State_____ Zip_________

Tel__________________ Fax____________________Email ______________________________

License#__________________ NPI#__________________ UPIN#__________________ DEA# __________________

Prescriber's Signature (signature required. NO STAMPS)______________________________ **Date**________________

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