Please fax both pages of completed form to your team at 877.251.5897.

To reach your team, call toll-free 877.445.3951.

You can now monitor shipments and chat online if you have questions. Go to <u>MyAccredoPatients.com</u> to log in or get started.

Prescription & Enrollment Form Fasenra[®] (benralizumab)

Current patient

Four simple steps to submit your referral.

accredo

1 Patient Information

New patient

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	1
	2

Please provide copies of front and back of all medical and prescription insurance cards.

Patient's first name		Last name	Middle initial
Sex at birth: Male Fem	ale Pronouns	Last 4 digits of S	SN Date of birth
Street address			Apt #
City		State	Zip
			Email address
Parent/guardian (if applicable)		
			Email address
Alternate caregiver/contact			
			Email address
OK to leave message with	alternate caregiver/contac	ct	
Patient's primary language:	English Other If o	other, please specify	

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date	Time		Date medication nee	ded	
Office/clinic/institu	ution name				
Prescriber info: Pre	escriber's first name		Last	name	
Prescriber's title _		If N	P or PA, under directi	on of Dr	
Office phone	Fax		_ NPI #	License #	
Office contact and	I title		Office	contact email	
Office street addre	ess			Suite #	
City		State _		Zip	
Infusion location:	Patient's home Prescribe	er's office Infusion site	If infusion site, cor	nplete information below dotted line:	
Infusion info: Infus	sion site name		Clinic/hospital a	filiation	
Site street address	S			Suite #	
City		State		Zip	
Infusion site contac	et	Phone	Fax	Email	
3 Clinic	al Information				
ICD-10 code (REQ	UIRED):				
NKDA Know	wn drug allergies				
Prior anaphylactic	reaction: Yes (Reason/date	e) No
Concurrent meds					
Concomitant thera Inhaled corticos		onist Long-acting bet ers Oral steroids N	0	mines Decongestants Immunoth r	erapy

Lab results: History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment serum IgE level	_IU per mL T	Fest date	Pre-treatment serum	eos	inophils	_cells/mcL and/or
sputum eosinophils	Da [.]	te	Patient wt	kg	Date wt obtained	

MD Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician Other _____

Prescription type: Naïve/new start Restart Continued therapy

Prescription & Enrollment Form: Fasenra® (benralizumab)

Patient's first name	Last name	Middle initial	Date of birth
Prescriber's first name	Last name	Phone	

4 Prescribing Information

Medication	Strength / Formulation and Directions	Quantity/Refills
Fasenra® (benralizumab) 30mg/mL solution in a	Starter Dose: Inject 30mg under the skin every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter.	1-month supply 3-month supply
single-dose prefilled syringe Fasenra® (benralizumab) 30mg/mL auto-injector pen	Maintenance Dose: Inject 30mg under the skin every 8 weeks.	Other: Refills

Fasenra Prefilled Syringe Ship to Home Authorization for Administration at MDO (excluding Virginia)

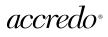
I,, (Prescriber's full name) as treating healthcare provider for					
(Patient's full name)	(Patient's DOB) am requesting Fasenra® (benralizumab)				
prefilled syringe be dispensed by Accredo to the patient's home, but will be administered in office or infusion clinic.					

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

HERE	Date	Dispense as written	Date	Substitution allowed	_

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.



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