

Prescription & Enrollment Form
Fasenra™ (benralizumab)



2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's first name _____ Last name _____
 Prescriber's title _____
 If NP or PA, under direction of Dr. _____
 Office contact and title _____
 Office contact email _____
 Office/clinic/institution name _____
 Clinic/hospital affiliation _____
 Street address _____ Suite # _____
 City _____ State _____ Zip _____
 Phone _____ Fax _____
 NPI # _____ License # _____
 Deliver product to: Office Patient's home Clinic
 Clinic location _____

1 PATIENT INFORMATION

New patient Current patient

Patient first name _____
 Last name _____ Middle initial _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____
 Work phone _____
 Cell phone _____
 Evening phone _____
 E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____
 Phone _____
 Insured's name _____
 Insured's employer _____
 Relationship to patient _____
 Identification # _____
 Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____
 Is patient eligible for Medicare? Yes No
 Does patient have a secondary insurance? Yes No

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
 NKDA Known drug allergies _____
 Prior anaphylactic reaction: Yes (Reason/date _____) No
 Concurrent meds _____
 Concomitant therapies: Short-acting beta agonist Long-acting beta agonist
 Antihistamines Decongestants Immunotherapy Inhaled corticosteroid
 Leukotriene modifiers Oral steroids Nasal steroids Other _____
 Lab results: History of positive skin OR RAST test to a perennial aeroallergen
 Pre-treatment serum IgE level _____ IU per mL Test date _____
 Pre-treatment serum eosinophils _____ cells/mcL and/or
 sputum eosinophils _____ Date _____
 Patient wt _____ kg Date wt obtained _____
 MD Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician
 Other _____
 Prescription type: Naïve/new start Restart Continued therapy

4 PRESCRIBING INFORMATION

Medication	Strength / Formulation and Directions	Quantity/Refills
<input type="checkbox"/> Fasenra™ (benralizumab) 30 mg/mL solution in a single-dose prefilled syringe <input type="checkbox"/> Fasenra™ (benralizumab) 30 mg/mL auto-injector pen	<input type="checkbox"/> Starter Dose: Administer 30 mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: Administer 30 mg subcutaneously every 8 weeks.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other: _____ Refills _____

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

By signing below, I certify that the above therapy is medically necessary.
 Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

 Date _____ Substitution allowed _____ Date _____ Dispense as written _____

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.

Please fax completed form to your team at 877.251.5897.

To reach your team, call toll-free 877.445.3951.

**You can now track shipments for all your Accredo patients.
 Go to <https://prescribers.accredo.com> and click "Help" to register.**