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(benralizumab)

FASENRA injection orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS Please provide ICD-10 code

- _____ Severe persistent asthma, uncomplicated
- _____ Severe persistent asthma with (acute) exacerbation
- _____ (other)

PRE-MEDICATION

- | | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____ (other) | <input type="checkbox"/> _____ (other) |

FASENRA ORDERS

DOSAGE	PATIENT WEIGHT
<input checked="" type="radio"/> 30mg SQ, every 8 weeks	_____ lbs.
<input type="radio"/> 30mg SQ every 4 weeks x 3 doses, then every 8 weeks	_____ kg

NOTES

ORDERING PROVIDER

Signature X _____ Date _____