Sarah Bush Lincoln

NOTE: PLEASE COMPLETE ELECTRONIC VERSION, PRINT AND FAX .... Handwritten forms will not be accepted.

PATIENT INFORMATION

Name: | DOB:

Allergies: | Date of Referral:

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)

Preferred Location* ☐ Mattoon ☐ Effingham

*Please Note: Requests will be accommodated based on infusion center availability and are not guaranteed.

Diagnosis and ICD 10 CODE

☐ Severe Eosinophilic Asthma — ICD 10 Code: J45.50

☐ Eosinophilic Granulomatosis with Polyangitis (EGPA) — ICD 10 Code: M30.1

☐ Other: ____ — ICD 10 Code: ______________

Does your patient have blood eosinophil counts ≥ 300 cells/μL within past 12 months? ☐ Yes ☐ No

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Pulmonary Function Tests

*Patient may be required to submit a pregnancy test prior to treatment

☐ Clinical/Progress notes (must be within 1 year)

☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

Dosing Wt for Calculations Ht: Wt (in kg): BMI:

Initial Dosing	☐ J0517 Fasenra 30mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
EGPA Dosing (adults only)	☐ J0517 Fasenra 30mg SubQ every 4 weeks
Pediatric Dosing (age 6-11)	
Weight <35 kg	☐ J0517 Fasenra 10mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
Weight ≥35 kg	☐ J0517 Fasenra 30mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
Maintenance Dosing	☐ J0517 Fasenra 30 mg SubQ every 8 weeks

Duration ☐ **X 6 months** ☐ **X 1 year** ☐ ________ **doses**

ADDITIONAL ORDERS / INFORMATION

PRESCRIBER INFORMATION

Prescriber name :

Office Phone: | Office Fax: | Office Email:

Prescriber Signature: | Date: | Time:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Contact us with questions at: SBL Infusion Center
Ph. 217-258-4150
217-342-7500

Fax Completed Form and all documentation to: Fax 217-342-7499

MEDICATION ORDERS - FASENRA (BENRALIZUMAB)

Clinics Scan to: Physician Orders