MPP INFUSION CENTERS
www.mppinfusion.com

Fax Referrals To: (855) 891-2191
Email Referrals To: MPPReferral@mppinfusion.com
Have a Question? (855) 478-1528

FASENRA® (BENRALIZUMAB) ORDER FORM

(- Required Fields)*

___ **STAT REQUEST**
(*REASON MUST BE PROVIDED BELOW)

_____ **New Referral** _____ **Order Renewal** _____ **Medication/Order Change**
_____ **Benefits Verification Only** _____ **Discontinuation Order**

PATIENT INFORMATION			
NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: ☐LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION		
PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

FASENRA ORDER*:

*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: _____

___ **Initial Dosing and then Maintenance Dosing:**
30 mg injection every 4 weeks for the first 3 doses, then every 8 weeks

OR

_____ **Maintenance Dosing:** 30 mg injection every 8 weeks

Physician Signature* _____ **Date*(Order is Valid for One Year)** _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

_____ Severe Asthma

_____ Eosinophilic Asthma

_____ Other_____

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

REQUIRED DOCUMENTATION CHECKLIST:

_____ Patient Demographics

_____ Insurance Card/Information

_____ Clinical/Progress Notes supporting DX

_____ Current Medication List and H&P

_____ Absolute Eosinophil Count (> 300 in prior 12mos or > 150 in prior 6 weeks)

Last Infusion/Injection Date: _____

NOTES/ADDITIONAL COMMENTS:

Locations:

--------**Colorado**--------
___ Lakewood

---------**Florida**---------
___ Jacksonville
___ Kissimmee
___ Port St. Lucie
___ Suncoast
___ Winter Park

----------**Texas**----------
___ Arlington
___ Cedar Hill
___ Dallas
___ Denton
___ Ft. Worth
___ Irving
___ Rockwall
___ Southlake
___ Flower Mound
___ Plano
___ Tyler

REVISION DATE- 03/2021