FASENRA®

Please Fax Completed Form To: **888-898-9113**

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________ Alt. Phone: ______________

Email: ______________ SS#: ______________

Gender: ☐ M ☐ F Weight: ________(lbs) Ht: __________

Allergies: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________

State License: ______________________

NPI #: ______________ DEA: ______________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________ Fax: ______________

Office Contact: ______________ Phone: ______________

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ______________________

City, State, Zip: ______________________

Plan #: ______________________

Group #: ______________________

Phone: ______________________

RX Card (PBM): ______________________

BIN: ______________ PCN: ______________

City, State, Zip: ______________________

Group #: ______________________

Phone: ______________________

Secondary Insurance (If Applicable):

Secondary Insurance: ______________________

Plan #: ______________________

Phone: ______________________

City, State, Zip: ______________________

Group #: ______________________

CLINICAL INFORMATION

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) ☐ Other: ______________

Is Patient Receiving Medium to High Dose Corticosteroids? ☐ Yes ☐ No (If Yes, Please List Medication): ______________

Is Patient Receiving an Additional Controller Medication? ☐ Yes ☐ No (If Yes, Please List Medication): ______________

☐ History of positive skin or specific IgE (test to perennial aeroallergen)

Absolute Eosinophil Count: __________ cells/mcL Pre-treatment serum IgE level: __________ IU/mL

Number of severe asthma exacerbations in the past 12 months: ________ Number of ED visits or hospitalizations in the past 12 months: ________

FASENRA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: __________ Date of Last Injection: __________

Medication	Directions	Quantity/Refills
☐ Fasenra® (benralizumab) 30mg/mL	☐ Starter Dose: Inject 30mg under the skin every 4 weeks for the first 3 doses, followed by once every 8 weeks subsequently. ☐ Maintenance Dose: Inject 30mg under the skin once every 8 weeks ☐ Other: ______________	☐ 1-month supply ☐ Other: __________ Refills: __________

Special Instructions: ______________________

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X______________________ Date: ______________

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.