Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

FASENRA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ Diagnosis

☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation

■ Details Needed for Authorization

Please answer all questions and provide supporting documentation.

- Is the patient 12 years old or older? _____
- What type of asthma (allergic, steroid-dependent, eosinophilic, etc) does the patient have? _____

For patients initiating Fasenra therapy:

- Does the patient have asthma symptoms throughout the day? _____
- Does the patient have a baseline blood eosinophilic count of 150 cells/mcl or higher while on steroids? _____
- Does the patient have an eosinophilic count of 150 cells/mcl or higher in the past 6 weeks? _____ Higher than 300 cells/mcl ever? _____
- On steroids: Does the patient has an FeNO of ≥20 ppb? _____ Does the patient have sputum eosinophils of ≥2%? _____
- Is the patient's asthma inadequately controlled on med-to-hi inhaled steroids plus an additional inhaled medication? _____
- Does the patient have ≥2 exacerbations per year requiring oral steroid treatment? _____
- Has the patient failed on or contraindicated for Xolair, Cinqair, Dupixent, Tezspire or Nucala? _____ If yes, please provide details.
- Will the patient be concurrently treated with Xolair, another IL-5 antagonist, Dupixent or Tezspire? _____
- Will the patient be concurrently treated with any other asthma medications? _____ If yes, which? _____
- Fasenra is not approved for bronchospasm or status asthmaticus. Will the patient be using Fasenra for either of these conditions? _____
- For non-Medicare patients: What is the reason the patient cannot self-administer with a prefilled pen? _____
- Please provide documentation of the baseline clinical status, including forced expiratory volume and # of exacerbations in past 6 months, steroid use in past 6 months, rescue med use in past 6 months, and # of hospitalizations or ER visits in the past 6 months.

For patients continuing on Fasenra therapy:

- Is the patient's asthma well controlled by Fasenra as demonstrated by a reduction of severity/symptoms? _____
- Is the patient's asthma well controlled by Fasenra as demonstrated by a reduction of daily maintenance meds or steroids? _____
- Does the patient had ≥2 exacerbations per year requiring oral steroid treatment? _____
- Fasenra is not approved for bronchospasm or status asthmaticus. Will the patient be using Fasenra for either of these conditions? _____
- For non-Medicare patients: What is the reason the patient cannot self-administer with a prefilled pen? _____
- Please provide documentation of the patient's asthma status while on Fasenra demonstrating its effectiveness.

■ Fasenra (benralizumab) Medication Order

Patient's height in ft/in: _____ Patient's weight in lbs: _____

☐ 30mg Fasenra prefilled syringe administered SQ once every 4 weeks for 3 doses.

☐ 30mg Fasenra prefilled syringe administered SQ once every 8 weeks for _____ (time period). [When was last dose, if not done here? _____]

Medication shall be brought to room temperature 30 minutes before injection. Administer according to manufacturer instructions. Check vitals and monitor for signs and symptoms before administration and after completion.

■ Rescue Management in case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone Line to Contact Person: _____

ADDITIONAL DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.