Sarah Bush Lincoln

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

☐ Other: _____ ICD 10 Code: _____

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

REQUIRED DOCUMENTATION

☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis, including blood eosinophil counts
☐ Pulmonary Function Tests	
☐ Pregnancy Test (if applicable)	

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

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

Initial Dosing	☐ Fasenra 30mg SubQ every 4 weeks for three doses then every 8 weeks thereafter
Maintenance Dosing	☐ Fasenra 30 mg SubQ every 8 weeks

Refills: ☐ **X 6 months** ☐ **X 1 year** ☐ _____ **doses**

ADDITIONAL ORDERS

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:
Fax Completed Form and all documentation to:

☐ MATTOON
1000 Health Center Dr. Suite 204
Mattoon, IL 61938
Ph. 217-258-4150
Fax 217-348-2579

☐ EFFINGHAM
901 Medical Park Dr. Suite 201
Effingham, IL 62401
Ph. 217-342-7500
Fax 217-342-7499

MEDICATION ORDERS - FASENRA (BENRALIZUMAB)

Clinics Scan to: Physician Orders