## *Intravene* – Fasenra Injection Orders (rev 1/2018)

**Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434)947-3900 ext. 2172**

**PATIENT INFORMATION**

Name ______________________________
Address ______________________________
City ______________________________
State _____________ Zip Code ________
Home Phone # ________________________
Work Phone # ________________________
DOB _________SSN _________________
Height ___________ Weight ________lbs
Drug Allergies________________________
□ NKDA Sex: □ Male or □ Female

**REFERRING PHYSICIAN INFORMATION**

Physician Name ___________________________
Physician Address_________________________
_________________________________________
Physician Phone(_____)_____________________
Physician Fax(____)________________________
NPI#__________________DEA#_____________
State License#______________________________

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**DIAGNOSIS (ICD-10 required)**

☐ ______________________________ ______________________________
☐ ______________________________ ______________________________
☐ ______________________________ ______________________________

| Other Asthma Therapies (tried and/or failed) | Name of Drug | Date Failed |
| --- | --- | --- |
| □ Short–acting Beta-agonist | ____________________ | ____________________ |
| □ Inhaled Corticosteroids (without LABA) | ____________________ | ____________________ |
| □ Long-acting Beta-agonist (without ICS) | ____________________ | ____________________ |
| □ Combination Therapy (LABA/ICS) | ____________________ | ____________________ |
| □ Oral or Injectable Steroids | ____________________ | ____________________ |
| □ Other (specify) | ____________________ | ____________________ |

**LAB RESULTS:**

Eosinophil levels:________cells/ul Test Date:______________
Allergies:____________________ Comorbidities:__________________________

**PRESCRIPTION:**

**Prescription Type: □ Naïve patient □ Restart □ Continue therapy**

**Dispense: Fasenra 30mg Subcutaneously every 4 weeks for 3 doses then every 8 weeks**
**Duration: □ 1 year □ other____________**

**Signature, prescribing MD ________________________ Date _______________**

**Anaphylactic meds available at the bedside**:
Epinephrine 1:1000 1mg ampule. Administer 0.5ml (0.5mg) by SQ injection upon order of MD
Hydrocortisone 100mg vial. Administer 100mg IV push upon order of MD
Diphenhydramine 50mg vial. Administer 50mg IV push upon order of MD

**VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL**