Please fax both pages of completed form to your team at 808.650.6487.
To reach your team, call toll-free 808.650.6488.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Fasenra® (benralizumab)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name ______ Last name ______ Middle initial ______

Sex at birth: Male Female Pronouns ______ Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ Email address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ Email address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ Email address ______

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify ______

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ______ Time ______ Date medication needed ______

Office/clinic/institution name ______

Prescriber info: Prescriber's first name ______ Last name ______

Prescriber's title ______ If NP or PA, under direction of Dr. ______

Office phone ______ Fax ______ NPI # ______ License # ______

Office contact and title ______ Office contact email ______

Office street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion location: Patient's home Prescriber's office Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name ______ Clinic/hospital affiliation ______

Site street address ______ Suite # ______

City ______ State ______ Zip ______

Infusion site contact ______ Phone ______ Fax ______ Email ______

3 Clinical Information

ICD-10 code (REQUIRED): ______

NKDA Known drug allergies ______

Prior anaphylactic reaction: Yes (Reason/date ______) No

Concurrent meds ______

Concomitant therapies: Short-acting beta agonist Long-acting beta agonist Antihistamines Decongestants Immunotherapy Inhaled corticosteroid Leukotriene modifiers Oral steroids Nasal steroids Other ______

Lab results: History of positive skin OR RAST test to a perennial aeroallergen

Pre-treatment serum IgE level ______ IU per mL Test date ______ Pre-treatment serum eosinophils ______ cells/mcL and/or sputum eosinophils ______ Date ______ Patient wt ______ kg Date wt obtained ______

MD Specialty (required): Allergist Pulmonologist ENT Primary care Pediatrician Other ______

Prescription type: Naïve/new start Restart Continued therapy

Patient's first name ______________ Last name ______________ Middle initial ____ Date of birth ________

Prescriber's first name ______________ Last name ______________ Phone ______________

4 Prescribing Information

Medication	Strength / Formulation and Directions	Quantity/Refills
Fasenra® (benralizumab) 30mg/mL solution in a single-dose prefilled syringe Fasenra® (benralizumab) 30mg/mL auto-injector pen	**Starter Dose:** Inject 30mg under the skin every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. **Maintenance Dose:** Inject 30mg under the skin every 8 weeks.	1-month supply 3-month supply Other: ______________ Refills ______________

Fasenra Prefilled Syringe Ship to Home Authorization for Administration at MDO (excluding Virginia)

I, ________________________, (Prescriber's full name) as treating healthcare provider for ________________________ (Patient's full name) ____________ (Patient's DOB) am requesting Fasenra® (benralizumab) prefilled syringe be dispensed by Accredo to the patient's home, but will be administered in office or infusion clinic.

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

Prescriber's signature (sign below) **(Physician attests this is his/her legal signature. NO STAMPS)**

SIGN HERE

________ **Date** ________________ **Dispense as written** ________ **Date** ________________ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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