

Please fax both pages of completed form to your team at 877.251.5897.

To reach your team, call toll-free 877.445.3951.

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®

Four simple steps to submit your referral.

1 Patient Information



Please attach copies of front and back of patient's insurance cards.

New patient Current patient

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

Male Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail 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 _____

Prescriber's first name _____ Last name _____

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

Office address _____

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/Infusion clinic name _____ Office/Infusion clinic affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Deliver product to: Office Patient's home Clinic Clinic location _____

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
<input type="checkbox"/> Fasenra® (benralizumab) 30mg/mL solution in a single-dose prefilled syringe <input type="checkbox"/> Fasenra® (benralizumab) 30mg/mL auto-injector pen	<input type="checkbox"/> Starter Dose: Administer 30mg subcutaneously every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter. <input type="checkbox"/> Maintenance Dose: Administer 30mg subcutaneously every 8 weeks.	Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other: _____ Refills _____

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)

PHYSICIAN SIGNATURE REQUIRED

**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.