FASENRA (benralizumab) Referral Order Form

FAX (877) 637-6691

VASCO INFUSION
WWW.VASCOINFUSION.COM
PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions *indicate name of drug(s) _____

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

FASENRA MEDICATION ORDERS

Dose: ☐ 30mg/ml single dose prefilled syringe Maintenance Dose: ☐ Inject every 8 weeks.

Frequency: Every 4 weeks for the first 3 doses, followed by once every 8 weeks thereafter

INDICATION/DIAGNOSIS

☐ J45.50 Severe persistent asthma, uncomplicated
☐ J45.51 Severe persistent asthma with acute exacerbation
☐ Other _____

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____ _____
Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report (w/in past 6 months)

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ Eosinophils

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY