Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

FASENRA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds* _____

■ Diagnosis
☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with acute exacerbation
Type of asthma (allergic, eosinophilic, steroid-dependent, etc.): _____

■ Details Needed for Approval
For initiation of Fasenra Therapy:
- Does the patient have asthma symptoms throughout the day? _____
- Does the patient have a baseline blood eosinophilic count of 150 cells/mcl or higher while on steroids? _____
- Does the patient have an eosinophilic count of 150 cells/mcl or higher in the past 6 weeks? _____ Higher than 300 cells/mcl ever? _____
- On steroids: Does the patient has an FeNO of ≥20 ppb? _____ Does the patient have sputum eosinophils of ≥2%? _____
- Is the patient's asthma inadequately controlled on mid-to-hi inhaled steroids plus an additional inhaled medication? _____
- Does the patient have ≥2 exacerbations per year requiring oral steroid treatment? _____
- Has the patient failed on or contraindicated for Xolair, Cinqair, Dupixent, Tezspire or Nucala? _____ *If yes, please provide details.*
- Will the patient be concurrently treated with Xolair, another IL-5 antagonist, Dupixent or Tezspire? _____
- Will the patient be concurrently treated with any other asthma medications? _____ If yes, which? _____
- Fasenra is not approved for bronchospasm or status asthmaticus. Will the patient be using Fasenra for either of these conditions? _____
- **What is the reason the patient cannot self-administer with a prefilled pen?** _____
- Please provide documentation of the baseline clinical status, including forced expiratory volume and # of exacerbations in past 6 months, steroid use in past 6 months, rescue med use in past 6 months, and # of hospitalizations or ER visits in the past 6 months.

For continuation of Fasenra Therapy:
- Is the patient's asthma well controlled by Fasenra as demonstrated by a reduction of severity/symptoms? _____
- Is the patient's asthma well controlled by Fasenra as demonstrated by a reduction of daily maintenance meds or steroids? _____
- Does the patient had ≥2 exacerbations per year requiring oral steroid treatment? _____
- Fasenra is not approved for bronchospasm or status asthmaticus. Will the patient be using Fasenra for either of these conditions? _____
- **What is the reason the patient cannot self-administer with a prefilled pen?** _____
- Please provide documentation of the patient's asthma status while on Fasenra demonstrating its effectiveness.

■ Medication Order
☐ 30mg Fasenra prefilled syringe administered SQ once every 4 weeks for 3 doses.
☐ 30mg Fasenra prefilled syringe administered SQ once every 8 weeks for _____ (time period). [When was last dose, if not done here? _____]
Medication shall be brought to room temperature 30 minutes before injection. Administer according to manufacturer instructions. Check vitals and monitor for signs and symptoms before administration and after completion.

■ Rescue Management in Case of Reaction
These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:
- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.