

	St. Charles Health System Adult Ambulatory Infusion Order Benralizumab (FASENRA)	Patient Name: Date of Birth:
		<i>Patient Identification</i>
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		
Treatment Start Date: _____ Allergies: _____ Weight: _____ kg Height: _____ cm		
REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety		
<ol style="list-style-type: none"> 1. FACE SHEET with complete INSURANCE information and patient CONTACT information 2. Recent VISIT NOTE to support treatment (if not available in Epic) 3. LAB RESULTS for any required prescreening (if not available in Epic) 4. DIAGNOSIS CODE _____ 5. Patient NAME and DATE OF BIRTH on EVERY page faxed 		

GUIDELINES FOR ORDERING

1. Benralizumab is not indicated for the treatment of acute asthma symptoms or acute exacerbations.
2. Do not discontinue systemic or inhaled corticosteroids abruptly upon initiation of therapy with benralizumab. Decrease corticosteroids gradually, if appropriate.
3. Treat patients with pre-existing helminth infections before therapy with benralizumab. If patients become infected while receiving treatment with benralizumab and do not respond to anti-helminth treatment, discontinue benralizumab until parasitic infection resolves

NURSING ORDERS:

1. Benralizumab syringe may contain a small air bubble. Do not expel the air bubble prior to administration. Administer into the upper arm, thigh or abdomen.
2. Monitor patient for hypersensitivity reaction, including anaphylaxis, for 30 minutes after administration.
3. Vital Signs: Initial then PRN

MEDICATIONS:

1. Select one of the following dosing schedules:

<input type="checkbox"/>	Inject benralizumab 30 mg subcutaneously every 4 weeks for the first 3 doses, followed by, 30 mg once every 8 weeks, starting day 112
<input type="checkbox"/>	Inject benralizumab 30 mg subcutaneously once every 8 weeks
<input type="checkbox"/>	Inject benralizumab 30 mg subcutaneously once every 4 weeks
<input type="checkbox"/>	Other: _____

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction



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- 2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
- 3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
- 4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
- 5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
- 6. albuterol 2.5 mg/3 mL nebuler, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed