



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ DEA: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Plan #: _____	City, State, Zip: _____
Group #: _____	Group #: _____
Phone: _____	Phone: _____
Secondary Insurance (If Applicable):	
Secondary Insurance: _____	City, State, Zip: _____
Plan #: _____	Group #: _____
Phone: _____	

CLINICAL INFORMATION

J45.50 Severe persistent asthma, uncomplicated J45.51 Severe persistent asthma with (acute) Other: _____

Is Patient Receiving Medium to High Dose Corticosteroids? Yes No (If Yes, Please List Medication): _____

Is Patient Receiving an Additional Controller Medication? Yes No (If Yes, Please List Medication): _____

History of positive skin or specific IgE (test to perennial aeroallergen)

Absolute Eosinophil Count: _____ cells/mL Pre-treatment serum IgE level: _____ IU/mL

Number of severe asthma exacerbations in the past 12 months: _____ Number of ED visits or hospitalizations in the past 12 months: _____

FASENRA® ORDERS

Prescription type: New start Restart Continued therapy Total Doses Received: _____ Date of Last Injection: _____

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Fasenra® (benralizumab) 30mg/mL	<input type="checkbox"/> Starter Dose: Inject 30mg under the skin every 4 weeks for the first 3 doses, followed by once every 8 weeks subsequently. <input type="checkbox"/> Maintenance Dose: Inject 30mg under the skin once every 8 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1-month supply <input type="checkbox"/> Other: _____ Refills: _____

Special Instructions: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral

X _____ Date: _____
Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.