



NEWPORTSUPERIOR
MEDICAL & INFUSION

NEWPORT INFUSION FASENRA REFERRAL FORM

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NPI# 1184620866
newportinfusion.com

Today's Date _____

Date Needed _____

Patient Name _____ Date of Birth _____ ☐ Male ☐ Female

Address _____ Apt # _____ City _____ State _____ Zip _____

Telephone _____ Cell _____ SSN _____ Email _____

Allergies _____ Comorbidities _____

Current Medications (including OTC, if necessary, please fax a complete list) _____

Primary Insurance _____ ID# _____ Group # _____

Secondary Insurance _____ ID# _____ Group # _____

Insured's Name _____ Employer _____

City _____ State _____ Phone _____ Please attach patient's insurance cards, front and back

Diagnosis ☐ J45.50 Severe persistent asthma, uncomplicated ☐ J45.51 Severe persistent asthma with (acute) exacerbation
ICD-10 Code: ☐ Other _____

Patient currently on therapy? ☐ Yes ☐ No

Eosinophil count: _____ Cells/ μ L Date of test: ____/____/____

Number of asthma exacerbations
(requiring use of systemic
corticosteroids and/or hospitalization)
in last 12 months: _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS (Front and Back)

Medication	Directions	Quantity	Refills
Fasenra TM (benralizumab)	Initiation Dose: ☐ 30 mg/mL solution in single-dose syringe administered subcutaneously once every 4 weeks for first 3 doses	☐ 1	☐ 1
		☐ _____	☐ 2
	Maintenance Dose: ☐ 30 mg/mL solution in single-dose syringe administered subcutaneously once every 8 weeks	☐ 1	☐ 3
		☐ _____	☐ 4
			☐ _____ # Refills

Administration Method (choose one): ☐ Prefilled Syringe (Office-Administered) ☐ Pen (Self-Administered)

Has the patient been started on samples? ☐ Yes ☐ No

Total number of FASENRA (benralizumab) doses received since start date: _____ Date of last injection/treatment: _____

Please attach the following: Most Recent Progress Notes & Lab Results & Medication List

Thank you!

Prescriber's Name / Practice _____ Office Contact _____

Address _____ Suite# _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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Please fax completed referral form to
Newport Infusion at (949)484-4150