Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

# Fasenra Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F.(609)228-9798 Attn: Idyllic Infusion Coordinator

| | |
|---|---|
| **DATE**: | |
| **REFERRING PROVIDER INFORMATION** | |
| **Requesting Provider Name and NPI<br>Tax ID#** | **Name:<br>NPI:<br>Tax ID#** |
| **Fax Number** | |
| **Practice Contact (Name/Phone number)** | |
| **Contact Email** | |
| *We will gladly remind your patient to schedule routine follow-up visits with your office.*<br>**Return to Referring Provider (frequency): EVERY_____ WKS / MOS** | |
| **PATIENT INFORMATION** | |
| **Patient Name** | |
| **Date of Birth** | / / |
| **Height in ft/in:<br>Weight in lbs:** | |
| **Insurance(s): include copies of front and back** | |
| **Preferred Treatment Location** | ☐ Voorhees ☐ Moorestown<br>☐ Wall/Manasquan ☐ Sewell<br>☐ Hamilton ☐ Galloway |
| **Primary Care Physician (Name / Phone Number)** | PCP Name:<br>PCP Phone Number: |

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**Name (last, first) _____DOB: _____**

**Diagnosis:**
☐J45.50 Severe persistent asthma, uncomplicated
☐J45.51 Severe persistent asthma with (acute) exacerbation

**Please answer all questions and provide supporting documentation.**

- Is the patient 12 years old or older? _____
- What type of asthma does the patient have:
  ☐allergic ☐steroid-dependent ☐eosinophilic ☐Other, please list _____
- Does the patient have asthma symptoms throughout the day? _____
- Does the patient have a baseline blood eosinophil count of 150 cells/mcl or higher while on a steroid?_____
- Does the patient have an eosinophil count of 150 cells/mcl or higher in the past 6 weeks? _____ Higher than 300 cells/mcl every? _____
- On Steroids:
  - Does the patient have an FeNO of ≥ 20 ppb? _____
  - Does the patient have sputum eosinophil of ≥ 2%? _____
- Is the patient's asthma inadequately controlled on medium to high 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, 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? _____
- Please provide documentation of the baseline clinical status, including forced expiratory volume and # of exacerbations in the past 6 months, steroid use in the past 6 months.

**For all patients:**
- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- Does the patient have a history of anaphylaxis? _____
- Is this patient ambulatory ?
  - If no, is a wheelchair required _____
- Please include a copy of a prescription. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- Please notify our office if medication will be discontinued.

*Ordering Provider Signature* _____