ADULT AMBULATORY INFUSION ORDER
Benralizumab (FASENRA)
Subcutaneous Injection

Patient Identification

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: __________kg   Height: __________cm

Allergies: _________________________________

Diagnosis Code: _________________________________

Treatment Start Date: ___________   Patient to follow up with provider on date: ___________

**This plan will expire after 365 days at which time a new order will need to be placed**

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.
4. Benralizumab dosing: 30 mg subcutaneous every 4 weeks for the first 3 doses, and then once every 8 weeks

MEDICATIONS (select one):
Benralizumab (FASENRA) subcutaneous injection

☐ INITIATION + MAINTENANCE
  o 30 mg, subcutaneous, EVERY 4 WEEKS x3 doses
  - followed by -
  o 30 mg, subcutaneous, EVERY 8 WEEKS, starting day 112 (week 16)

☐ MAINTENANCE ONLY
  o 30 mg, subcutaneous, EVERY 8 WEEKS

Administer into the upper arm, thigh or abdomen. Prior to administration, remove prefilled syringe from refrigerator and allow to warm at room temperature for about 30 minutes. Solution is clear to opalescent, colorless to slight yellow liquid. Particles may be present in the solution that appear translucent or white to off-white. Do not use if cloudy or discolored. Syringe may contain a small air bubble. Do not expel the air bubble prior to administration. **HIGH ALERT MEDICATION**

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. Prior to administration, remove prefilled benralizumab syringe from the refrigerator and allow to warm at room temperature for 30 minutes
3. Benralizumab syringe may contain a small air bubble. Do not expel the air bubble prior to administration
4. Monitor patient for hypersensitivity reaction, including anaphylaxis, for 30 minutes after administration
HYPERSENSITIVITY MEDICATIONS:

1. **NURSING COMMUNICATION** – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.

2. **Diphenhydramine (Benadryl)** injection, 25-50 mg, intravenous, AS NEEDED x1 doses for hypersensitivity reaction, Max dose 50 mg.

3. **Epinephrine HCl (Adrenaline)** injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction.

4. **Famotidine (Pepcid)** injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction.

5. **Hydrocortisone sodium succinate (Solu-Cortef)** injection, 100 mg, intravenous, AS NEEDED x1 dose for hypersensitivity reaction.

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: □ Oregon □ ________________ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);

My physician license Number is # ________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

**Provider signature:** ___________________________  **Date/Time:** ______________________

**Printed Name:** ___________________________  **Phone:** _______________  **Fax:** ______________
OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

- **Beaverton**
  - OHSU Knight Cancer Institute
  - 15700 SW Greystone Court
  - Beaverton, OR 97006
  - Phone number: 971-262-9000
  - Fax number: 503-346-8058

- **Gresham**
  - Legacy Mount Hood campus
  - Medical Office Building 3, Suite 140
  - 24988 SE Stark
  - Gresham, OR 97030
  - Phone number: 971-262-9500
  - Fax number: 503-346-8058

- **NW Portland**
  - Legacy Good Samaritan campus
  - Medical Office Building 3, Suite 150
  - 1130 NW 22nd Ave.
  - Portland, OR 97210
  - Phone number: 971-262-9600
  - Fax number: 503-346-8058

- **Tualatin**
  - Legacy Meridian Park campus
  - Medical Office Building 2, Suite 140
  - 19260 SW 65th Ave.
  - Tualatin, OR 97062
  - Phone number: 971-262-9700
  - Fax number: 503-346-8058

Infusion orders located at: [www.ohsuKnight.com/infusionorders](http://www.ohsuKnight.com/infusionorders)