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Disclosure and Consent for Administration of Fasenra (benralizumab)

You have a right, as a patient, to be informed about your condition and the recommended treatments (including risks and benefits) to help you make informed decisions about your healthcare. If you have any questions about the information below, please ask Dr._____. Also, please understand that you are not required to take benralizumab. You may continue to receive care by this office, even if you decide against the benralizumab therapy.

I understand that Fasenra (benralizumab) is a humanized monoclonal antibody selective for Interleukin 5 receptor alpha subunit on eosinophils and attracts natural killer cells to induce self –destruction of eosinophils. Eosinophils are a type of white blood cell that contributes to the development of asthma. Fasenra reduces severe asthma attacks by reducing the levels of blood eosinophils.

I understand that Fasenra (benralizumab) is approved for add on maintenance treatment of patients with severe asthma in patients age 12 years and older with an eosinophilic phenotype. Fasenra is not indicated for rapid relief of an asthma attack or during asthma symptoms.

I understand that Fasenra is administered by subcutaneous injection by a health care professional into the upper arm, thigh, or abdomen, at a frequency of once every four weeks for the first three doses, and then every 8 weeks thereafter.

I understand that there can be side effects. The most common side effects of Fasenra include headache, sore throat, fever. Injection site reactions (local pain, redness, itch, bump) can occur in 2.2% of patients with Fasenra, which is similar to the rate of local reactions in placebo injections. Hypersensitivity reactions have occurred within hours or occasionally days after being treated with Fasenra, including hives, angioedema (swelling of the face, mouth, and tongue), rash or anaphylaxis (severe life threatening allergic reactions that can include but are not limited to trouble breathing, lightheadedness or drop in blood pressure etc). I will carry my EpiPen/Auvi Q with me at all times in case of a severe allergic reaction.

I understand that I should not change or stop taking my other asthma medications during Fasenra treatment unless instructed to do so by my Dr. _____. I may not see immediate improvement in my asthma after starting Fasenra.

My signature below indicates that this form has been fully explained to me and I have had opportunities to ask questions. My questions have been answered and it is my wish to be treated with Fasenra for severe asthma.

Patient _____

Patient/Guardian Signature_____Date_____

Physician_____