

PATIENT INFORMATION

PATIENT NAME: _____ PHONE: _____

DATE OF BIRTH: _____ SEX: M F HEIGHT: _____ WEIGHT: _____ LBS KG

ALLERGIES: _____ PREFERRED CLINIC: _____

REFERRAL STATUS: NEW REFERRAL ORDER CHANGE ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

J45.50 Severe persistent asthma, uncomplicated

J45.51 Severe persistent asthma with (acute) exacerbation

J82.83 Eosinophilic Asthma

ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

Insurance Information

List of Medications

Tried & Failed Therapies

Most Recent History & Physical

Blood Eosinophil Level/CBC

Lab results and/or Pulmonary Function Tests to support diagnosis
(if required by insurance plan)

MEDICATION ORDER

EXDENSUR® (depemokimab-ulaa) 100 mg via subcutaneous injection every 6 months into the upper arm, thigh, or abdomen.

REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first injection and then for 15 minutes following each subsequent injection. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ NPI #: _____

EMAIL: _____ PHONE: _____ FAX: _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN