EXDENSUR

(depemokimab-ulaa)

Advanced Infusion Care Centers®

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Severe persistent asthma, uncomplicated (J45.50)

☐ J82.83 Eosinophilic asthma (J82.83)

☐ Severe persistent asthma with acute exacerbation (J45.51)

☐ Other: _____

PRESCRIPTION

EXDENSUR

☐ EXDENSUR 100 mg subQ every 6 months x 1 year

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card & Patient Demographics
- H&P with asthma exacerbation history
- Patient Demographics
- Tried/Failed Therapies
- Documentation of failed ICS/LABA +/- LAMA
- Baseline Eosinophil count
- Spirometry/PFT Reports

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol.
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other adverse reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended pre-medications for this medication.

☐ Provider Prescribed: _____

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

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