

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex: M F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ lbs kg

Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_

Patient Preferred Location: \_\_\_\_\_

**Diagnosis****Primary ICD 10 Code (Required)**J82.83 Eosinophilic Asthma  
J44.50 Severe Persistent Asthma  
J45.51 Severe Persistent Asthma, w/Acute Exacerbation

Other: \_\_\_\_\_

**Patient Status:**New to Therapy  
Continuing Therapy (Date of Last Dose \_\_\_\_\_ )**Infusion Orders****EXDENSUR (depemokimab-ulaa)****Dose for patients 12 Years and older:**

Inject 100 mg subcutaneously to the upper arm, thigh, or abdomen every 6 months for one year

**Premedications:**

Tylenol: \_\_\_\_\_ 325 mg / 500 mg / 650 mg PO

Diphenhydramine: \_\_\_\_\_ 25 mg / 50 mg PO

Diphenhydramine: \_\_\_\_\_ 25 mg / 50 mg IV

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Is the patient on any other disease modifying therapy? Yes No

If yes, please note last therapy dose: \_\_\_\_\_

*Medix Infusion will collect all necessary labs if not included in referral documents.***Adverse Events:** In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.**Other Orders:**  
\_\_\_\_\_**Required Clinical Documentation**

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

**Lab Results:**

Blood eosinophil level OR CBC with differential AND pulmonary function test prior to initiating therapy

**Referring Patient Information**

Prescriber Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NPI #: \_\_\_\_\_

Supervising Physician (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_