Exdensur® Order Form
(depemokimab-ulaa)

FAX TO: 972.499.9210

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 ICD 10 Code: _____

Description: _____

Patient Status

☐ New to Therapy

☐ Continuing Therapy (Date of Last Dose _____)

Medication Order

EXDENSUR (depemokimab-ulaa)

Dose for Patients 12 Years and Older

☐ Inject 100 mg subcutaneously to the upper arm, thigh, or abdomen every 6 months thereafter unless discontinued

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Comments: _____

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

Is the patient on any other disease modifying therapy?

☐ Yes ☐ No

If yes, please note therapy and last dose:

_____

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____