

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code Required** Severe Asthma (J45.50-J45.52), ICD10 _____
 Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Exdensur® (depemokimab)	100 mg	Inject SUBQ once every 6 months x 1 year. <input type="checkbox"/> Observe patient for 1-2 hours after each dose

Is patient currently receiving therapy above from another facility? If yes, Facility Name: _____
 Yes No Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

No premeds ordered at this time
 Acetaminophen 650mg PO Diphenhydramine 25mg PO
 Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP
 Other: _____

LAB ORDERS

Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____
 ESR q _____ LFTs q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ NPI: _____ TIN: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS for ASTHMA DIAGNOSIS (required)

Pre-treatment serum eosinophil level Other: _____
 Pre-treatment pulmonary function test
 FEV-1 <80% predicted
 FEV-1 reversibility ≥12% and 200mL after albuterol administration

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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