Email: intake@infuseone.com | Phone: 833-881-6048 | Fax: 888-261-6644

INFUSE ONE

Exdensur® Order Form (depemokimab-ulaa)

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: _____

Infuse One will collect all necessary labs if not included in referral documents.

Adverse Events: In the event of an adverse reaction occurring at a Infuse One suite, utilize the Infuse One 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: _____