

Exdensur (depemokimab-ulaa)

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal
Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:	DOB:	
<input type="checkbox"/> NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:		Next Due Date:	
PROVIDER INFORMATION			
Office Contact Name:		Office Email:	
Prescribing Providers Name:		Provider NPI:	
Office Address:		City:	State: Zip:
Office Phone Number:		Office Fax Number:	
DIAGNOSIS AND ICD 10 CODE			
<input type="checkbox"/> Severe persistent asthma, uncomplicated J45.50			
<input type="checkbox"/> Severe persistent asthma with (acute) exacerbations J45.51			
<input type="checkbox"/> Eosinophilic asthma J82.83			
<input type="checkbox"/> Other: _____ ICD 10 Code: _____			
REQUIRED DOCUMENTATION/Testing			
<input type="checkbox"/> This signed order form by the provider		<input type="checkbox"/> Clinical/Progress notes supporting primary dx	
<input type="checkbox"/> Patient demographics AND insurance info		<input type="checkbox"/> Lab results to support diagnosis	
List Tried & Failed Therapies 1)		2)	
MEDICATION ORDERS			
<input checked="" type="checkbox"/> Exdensur 100mg SQ every 6 months			
Refills*: <input type="checkbox"/> None <input type="checkbox"/> X6 months <input type="checkbox"/> X1 year <input type="checkbox"/> Other: _____			
<i>*(if not indicated order will expire one year from date signed)</i>			
SPECIAL INSTRUCTIONS			

Provider Name (Print) _____ **Physician Signature:** _____ **Date:** _____

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.