# Exdensur

**(depemokimab-ulaa SQ injection)**

NobleInfusion
Phone: 386-957-9600
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**PATIENT INFORMATION:**

Patient Name: _____ ☐ Male ☐ Female

DOB: _____ Primary Phone #: _____ Alternate #: _____

Address:_____

Allergies: ☐ NKDA ☐ allergic to _____

Insurance Name _____ Member ID_____

☐ start new treatment ☐ continue treatment. ____ dose/s already complete. Date of last dose: _____

**STEP THERAPY (SELECT ALL THAT APPLY)**

**Tried and failed**: ☐ Fasenra ☐ Xolair ☐ Dupixent

**Currently Receiving**:

☐ high dose inhaled corticosteroids

☐ long acting beta-2 agonists such as Advair, Symbicort, and or Dulera

**DIAGNOSIS:**

☐ J45.50- severe persistent asthma uncomplicated ☐ other: _____

☐ J45.5- severe persistent asthma with acute exacerbation _____

☐ J82.83- Eosinophilic Asthma _____

**REQUIRED DOCUMENTATION**

Pretreatment Absolute Eosinophil Count (AEC): _____ Date: _____

Post/current Absolute Eosinophil Count (AEC): _____ Date: _____

- CBC w/ Differential, including actual AEC lab results
- Office notes documenting uncontrolled asthma. Ex: flares, ER visits/hospitalizations, persistent symptoms despite maintenance therapy
- Current medium-high dose ICS therapy: _____
- AND controller therapy: _____
- Insurance cards and demographics

**DOSING AND ADMIN**

☐ 100mg SQ once every 6 months - Admin Site options: abdomen, upper arm, thigh

**ORDERING PROVIDER**:

Name: _____ NPI _____

Phone: _____ fax: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Best contact name:_____ Position:_____ phone:_____

Provider Signature_____ Date: _____