

**Fairfield**  
1817 Black Rock Turnpike  
Suite 204  
Fairfield, CT 06824

**Greenwich**  
469 W Putnam Ave  
Ste 205,  
Greenwich, CT 06830



**EXDENSUR®** (depemokimab)  
Provider Order Form

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**LABORATORY ORDERS**

None required  
 CBC with differential (optional)  
 Other: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

None required  
 Acetaminophen \_\_\_\_\_ mg PO (optional)  
 Antihistamine (cetirizine or equivalent)  
 Other: \_\_\_\_\_

**EXDENSUR® (depemokimab)**

**THERAPY / MEDICATION ORDER**

**Treatment Status:**  
 New     Restart     Continuing

**Dose:** 100mg subcutaneous to upper arm, thigh, or abdomen every 6 months

**Refills:** \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

**NOTES/ADDITIONAL COMMENTS:**

**ORDERING PROVIDER**

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_