Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

EXDENSUR® (depemokimab)
Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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 _____