

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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: _____

<p>LABORATORY ORDERS</p> <p><input type="checkbox"/> None required <input type="checkbox"/> CBC with differential (optional) <input type="checkbox"/> Other: _____</p> <p>PRE-MEDICATION ORDERS</p> <p><input type="checkbox"/> None required <input type="checkbox"/> Acetaminophen _____ mg PO (optional) <input type="checkbox"/> Antihistamine (cetirizine or equivalent) <input type="checkbox"/> Other: _____</p>

<p>EXDENSUR® (depemokimab)</p> <p>THERAPY / MEDICATION ORDER</p> <p>Treatment Status: <input type="checkbox"/> New <input type="checkbox"/> Restart <input type="checkbox"/> Continuing</p> <p>Dose: 100mg subcutaneous to upper arm, thigh, or abdomen every 6 months</p> <p>Refills: _____</p> <p>SPECIAL INSTRUCTIONS</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>

<p>NOTES/ADDITIONAL COMMENTS:</p>
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ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____