

# Depemokimab-ulaa (Exdensur)

Provider Order Form rev. 04/20/2026



## PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

|                                                              |                               |                     |
|--------------------------------------------------------------|-------------------------------|---------------------|
| Patient Name:                                                | DOB:                          | Patient Phone:      |
| Patient Address:                                             | Patient Email:                |                     |
| Allergies:                                                   | <input type="checkbox"/> NKDA | Weight (lbs/kg):    |
| Sex: <input type="checkbox"/> M / <input type="checkbox"/> F | Date of Last Infusion:        | Height (in/cm):     |
| Next Due Date:                                               |                               | Preferred Location: |

## DIAGNOSIS (Please provide ICD-10 code in space provided)

|                                                                                     |                                                     |
|-------------------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> J45.50 Severe persistent asthma, uncomplicated             | <input type="checkbox"/> J82.83 Eosinophilic asthma |
| <input type="checkbox"/> J45.51 Severe persistent asthma with (acute) exacerbations |                                                     |
| Other:                                                                              | Description:                                        |

## THERAPY ADMINISTRATION & DOSING

☒ Administer Exdensur 100 mg subcutaneously

## FREQUENCY (Choose one)

- ☐ Every 6 months  
☐ Every \_\_\_\_\_ months

## ADDITIONAL ORDERS

|  |
|--|
|  |
|--|

## LABORATORY ORDERS

☐ Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

☐ Other: \_\_\_\_\_

## NURSING

- ☒ Hold infusion and notify provider for:
- current parasitic infection
  - new or worsening asthma symptoms since initiating therapy
  - Recent administration of live vaccines
- ☒ If indicated as required by provider, confirm patient has epinephrine auto-injector and understands indications for use.
- ☒ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

## PROVIDER INFORMATION

|                          |                          |        |           |
|--------------------------|--------------------------|--------|-----------|
| Preferred Contact Name:  | Preferred Contact Email: |        |           |
| Ordering Provider:       | Provider NPI:            |        |           |
| Referring Practice Name: | Phone:                   | Fax:   |           |
| Practice Address:        | City:                    | State: | Zip Code: |

## REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

**Required Documentation:** Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, Spirometry results, Pulmonary function test, hospitalizations, and flares

**Required Labs:** CRP/ESR, Eosinophil Count

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

**Disclaimer:** By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.