INTRAMED Plus
infusion services

EXDENSUR®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis:
_____ Severe persistent asthma, uncomplicated — ICD-10 Code: J45.50
_____ Severe persistent asthma with (acute) exacerbations — ICD-10 Code: J45.51
_____ Eosinophilic asthma — ICD-10 Code: J82.83
_____ Other: _____ — ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical documentation supporting primary diagnosis
- Exacerbation history
- Recent Lab/Test Results including:
  - o Baseline blood eosinophil (CBC with differential)
- Medication List

Patient
Weight: _____ lbs.
Height: _____ in.

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4. Drug Order: **Exdensur® (depemokimab-ulaa)** **J Code: J2361**

Administer 100 mg/mL by subcutaneous injection into the upper arm, thigh, or abdomen once every 6 months by a healthcare professional

Doses Authorized: 2 (two)

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed.

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.
Anaphylaxis Kit:

- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

By signing this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written — Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE	
CENTRAL FAX **803.999.1754**	**803.999.1750**	Access Intramed Plus prescription order forms here.