EXDENSUR (depemokimab-ulaa)

Horizon Infusions

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐LBS ☐Kg Gender ☐M ☐F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

- ☐ J45.50 - Severe persistent asthma, uncomplicated
- ☐ J45.51 - Severe persistent asthma with (acute) exacerbation
- ☐ M30.1 - Polyarteritis with lung involvement

DOSING

- ☐ Administer 100mg SubQ every 6 months
- ☐ Vital signs per HI Protocol
- ☐ Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS ☐N/A

- ☐ Acetaminophen ☐500mg ☐650mg ☐1000mg
- ☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
- ☐ Diphenhydrimine (Benadryl) ☐25mg ☐50mg ☐PO ☐IV (requires driver)
- ☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐80mg ☐125mg IV
- ☐ Prednisone _____ mg PO
- ☐ Other _____

POST-MEDICATIONS ☐N/A

- ☐ Acetaminophen ☐500mg ☐650mg ☐1000mg
- ☐ Prednisone _____ mg PO
- ☐ Other _____

LABS

Other (specify):

_____

Provider Signature _____ Date _____

For new referrals, please include recent labs and last two office visit notes.

Fax Referrals to: Kentucky (888) 977-0914 I New York (315) 457-4305 I Ohio (888) 977-0914 I Pennsylvania (724) 240-1586