Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Depemokimab-ulaa (Exdensur) Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F. (609)228-9798 attn: Idyllic Infusion Coordinator

DATE:			
REFERRING PROVIDER INFORMATION			
Requesting Provider Name and NPI Tax ID#	**Name:** **NPI:** **Tax ID#**		
Fax Number			
Practice Contact (Name/Phone number)			
Contact Email			
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY_____ WKS / MOS**			
PATIENT INFORMATION			
Patient Name			
Date of Birth	/ /		
Height in ft/in: **Weight in lbs:**			
Insurance(s): include copies of front and back			
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Sewell	☐ Galloway ☐ Hamilton ☐ Wall	☐ Haddon Heights

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

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Name (last, first) _____DOB: _____

Diagnosis:

- ☐ Eosinophillic Phenotype Asthma
- ☐ Other: _____

Please answer all questions and provide supporting documentation.

1. Will Exdensur be used as add-on maintenance treatment for severe eosinophilic phenotype asthma?
   ❒Yes ❒No
   a. If yes, please indicate the patient's daily medications and the dose prescribed for the treatment of this diagnosis:
   Drug/Dose: _____ Drug/Dose: _____
2. Blood eosinophil count: _____ Date Determined: _____
3. Does the patient require daily systemic corticosteroids despite compliant use with a medium-to-high dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication?
   ❒Yes ❒ No
   a. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within the last 12 months: Number: _____ Dates: _____
4. Please check all that apply:
   - ☐ The patient has failed a medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months.
     - Drug/Dose: _____
   - ☐ The patient has failed at least 1 other asthma controller medication used in addition to the medium-to-high-dose ICS consistently for at least the past 3 months.
     - Drug/Dose: _____
5. Please provide a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Dupixent®, Fasenra®, and Nucala® _____
   _____
   _____
6. Will Exdensur be administered by a health care professional? ❒Yes ❒ No
7. Is the prescriber an allergist, pulmonologist, or pulmonary specialist? ❒Yes ❒ No
   a. If no, has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? ❒Yes ❒ No

For all patients:

- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- Does the patient have a history of anaphylaxis? _____
- Is this patient ambulatory? If no, is a wheelchair required _____
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- Please notify our office if medication will be discontinued.

❒ The patient has been educated by the ordering provider on medication.

☐ **Administer Depemokimab-ulaa (Exdensur) 100mg subcutaneous injection every 6 months**

Ordering Provider Signature _____Date: _____