

Order Form

Patient Information:

Patient Name

DOB

Phone Number

Medical Information:

Primary Diagnosis:

- | | |
|--|---------------------|
| ☐ Severe persistent asthma, uncomplicated | ICD-10 Code: J45.50 |
| ☐ Severe persistent asthma with exacerbations | ICD-10 Code: J45.51 |
| ☐ Eosinophilic asthma | ICD-10 Code: J82.83 |
| ☐ Other _____ | ICD-10 Code _____ |

Allergies: _____ (or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
 - Documentation of treatments trialed/failed and exacerbation history
- Active Medication List
- Relevant labs and tests
- Required Information:
 - Baseline blood eosinophil (CBC with differential)

Height: _____

Weight: _____

Exdensus (depemokimab-ulaa) Order:

Administer 100 mg once every 6 (six) months via subcutaneous injection into the upper arm, thigh or abdomen to provide two (2) doses or 12 month supply.

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

Prescriber's Signature

Date

Prescriber's Printed Name

Contact Phone #:

Please fax the completed order form and all other requested information to: 601-714-1569

For Information About Revitalize and or Infusion Plus, please scan the QR code below:



Revitalize



Revitalize Locations



InfusionPlus