McLeod Health

Depemokimab-ulaa (Exdensur) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one):

☐ J82.83 Eosinophilic Asthma

☐ J45.51 Severe persistent asthma with (acute) exacerbation

☐ J45.50 Severe persistent asthma, uncomplicated

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

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

- Order Duration: One year unless otherwise specified (Other: _____)

Provider Attestation

☐Provider attestation that the patient or caregiver are not competent or are physically unable to administer the self-administered product.

☐Patient has a history of uncontrolled disease and ordering provider attests that in their clinical opinion; it is not advisable to try the self-administered formulation of the drug.

☐The location and circumstances for self-administration are not adequate for the potential treatment of anaphylaxis should that arise.

☐Patient has experienced severe hypersensitivity reactions to Nucala within the past 6 months and requires administration and direct monitoring by a healthcare professional: (please indicate specific reasons)

_____

☐Due to patients' weight, ordering provider attests that in their clinical opinion, it is not advisable to try the self-administered formulation of the requested drug.

Standing Orders:

- Monitor the patient for 30 minutes after each infusion for signs and symptoms of an infusion-related or hypersensitivity reaction.

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion/injection will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Approved: 06/2026
Last Reviewed: 06/2026

Pre-Screening Requirements:

- Blood eosinophil level (pre-treatment baseline count greater than or equal to 150 cells/mcL)
- For new patient referrals, please send history and physical and most recent physician note with completed plan.

Previous Therapies:

- Please send a complete and recently updated medication list, along with tried and failed therapies.
- If patient has previously received depemokimab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

the last date received: _____ and the required washout from previous therapy: _____

Additional Information

- Patient's may be ineligible to receive depemokimab if patient has signs/symptoms of parasitic infection, is currently being treated for parasitic infection or is having acute bronchospasm and/or asthma attack.

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.