



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: M F
Address: _____ City: _____ State: _____ ZIP: _____
Phone: _____ Email: _____ Ht: _____ Wt: _____
Please Attach: Insurance cards History & Physical Most recent labs Medication list
 NKDA Allergies: _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____
Provider NPI: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ ZIP: _____

REQUIRED INFORMATION

Documentation:
 Recent clinical and/or office visit notes supporting primary diagnosis
Tried and failed prescribed medications:
 Fasentra Xolair Cinqair Other (please specify): _____

MEDICATION ORDERS

ICD-10 Diagnosis Codes:
 J45.50 Severe persistent asthma, uncomplicated
 J45.51 Severe persistent asthma with (acute) exacerbations. X=0 uncomplicated, X=1 with exacerbation
 J82.83 Eosinophilic asthma
 Other: _____
 New to Therapy Continuation of Therapy: Date of last dose (if applicable): _____

DOSING/FREQUENCY:
 Exdensur is administered by subcutaneous injection
 100 mg injection once every 6 months
 Refills: _____ (if not indicated prescription will expire one year from date signed)

Sage Infusion Standing Orders:
 Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name _____ Provider Signature _____ Date _____

- Fax Number
 Brandon: (656) 218-9643
 Clearwater: (727) 977-9717
 Fort Myers: (239) 533-5962
 Gainesville: (352) 450-8886
 Lakeland: (863) 777-2528
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