

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57W 57Street
Suite 601
New York, NY 10019



Manhattan
225 E 70th Street
Suite 1E
New York, NY 10021

Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Manhattan
225 East 70th Street
New York, NY 10021

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Elmsford/Tarrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Office: 212-803-3339 Fax: 646-768-8600

Holbrook/Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

5 Towns
141 Washington Avenue
Cedarhurst, NY 11559

NYC Central Park West
115 Central Park West
Suite 15
New York, NY 10023

Woodbury
75 Froehlich Farm
Woodbury, NY 11797

Staten Island
27 New Dorp Lane
Staten Island, NY 10306

Long Beach
917 Beech Street
Long Beach, NY 11561

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Bronx
226 West 238th Street
Bronx, NY 10463

Spesolimab-sbzo (Spevigo)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

New Referral Referral Renewal Medication/Order Change Benefits Verification Only Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 Other: _____

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg / 650mg / 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg / 50mg PO / IV
 methylprednisolone (Solu-Medrol) 40mg / 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
 Dose: _____ Route: _____
 Frequency: _____

THERAPY ADMINISTRATION

Spesolimab-sbzo (Spevigo) in 100ml 0.9% sodium chloride,
• Dose: 900mg
• Frequency: one time infusion
• Route: intravenous
• Infuse over 90 minutes

Select for an additional 900mg dose to be given one week after the initial dose. Subsequent treatments may require additional insurance authorization.

Flush with 0.9% sodium chloride at infusion completion
Refills: Zero, one-time order. (If additional treatments are needed, please submit a new order form.)

SPECIAL INSTRUCTIONS

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____