Vermont
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Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Spesolimab-sbzo (Spevigo)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐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.)T)

SPECIAL INSTRUCTIONS

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____