

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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.)T

SPECIAL INSTRUCTIONS

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____