

Spevigo (Spesolimab-sbzo)

PATIENT INFORMATIONReferral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION**NURSING** TB status & date (list results here & attach clinicals)
_____**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.)

Evaluate patients for TB prior to initiating treatment with Spevigo.

SPECIAL INSTRUCTIONS
_____**PROVIDER INFORMATION**

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Provider Name (Print)_____
Provider Signature_____
Date