Fax: 832-895-4040
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adaptIV infusion

Spevigo (Spesolimab-sbzo)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral 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)

____

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

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.)

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* __________

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK