Phone: (847) 324-6800 Fax: (224) 251-7141 Email: intake@infusacare.com

InfusaCare
Medfuse

Spevigo (Spesolimab-sbzo)

Patient Name: DOB: ☐ Male ☐ Female

Diagnosis (please provide ICD10 code):

☐ Other:

☐ NKDA ☐ Allergies:

☐ New Therapy Order ☐ Continuation of Therapy Date of last dose:

Ordering Provider Name:

Provider NPI: Phone: Fax:

Practice Address: City: State: Zip Code:

Pre-Medication

☐ Acetaminophen ______mg by ☐ PO
☐ Ceterizine ______mg by ☐ PO
☐ Diphenhydramine ______mg by ☐ PO/ ☐ IVP
☐ Solu-Medrol ______mg by ☐ PO/ ☐ IVP
☐ Solu-Cortef ______mg by ☐ PO/ ☐ IVP
☐ Other:

Required Documentation:

☐ Patient Demographics
☐ Patient Insurance (med and pharm card copies, front and back)
☐ Progress Notes/Labs supporting diagnosis
☐ Labs: CBC, CMP, CRP
☐ Other:

Patient height and weight:

Patient Height (cm): Patient Weight (kg):

Spevigo Medication Order:

- Dosage (choose one)
  - ☐ 900 mg
  - ☐ Other: ___________________________
- Frequency (choose one)
  - ☐ One time dose
  - ☐ Two doses one week apart
  - ☐ Other: ___________________________

Laboratory Order:

- CBC (choose one)
  - ☐ At each dose
  - ☐ Every ______________________________________
- CMP (choose one)
  - ☐ At each dose
  - ☐ Every ______________________________________
- CRP (choose one)
  - ☐ At each dose
  - ☐ Every ______________________________________
- Other: ____

Additional Instructions/Notes:

Ordering Provider:

Signature: ____ Date: __________________

Provider: ____ Phone: _________________ Fax: ___________________

Best Contact Person in Office: ________________________________ Phone: _________________

Updated: 1/15/2024