

# Spevigo® (spesolimab) Referral Form



**Preferred Clinic** (select one):

## PATIENT INFORMATION

New Referral

Updated Referral

Referral Renewal

|                         |                     |                      |                    |
|-------------------------|---------------------|----------------------|--------------------|
| DOB:                    | Patient Name:       | Patient Phone:       |                    |
| Patient Address:        |                     | Patient Email:       |                    |
| NKDA Allergies:         |                     | Weight (lbs/kg):     | Height:            |
| ICD-10 Code (required): | ICD-10 Description: | Last Treatment Date: | Last 4 Digits SSN: |

## PROVIDER INFORMATION

|  |        |                             |                  |
|--|--------|-----------------------------|------------------|
| Referral Coordinator Name:             |        | Referral Coordinator Email: |                  |
| Ordering Provider:                     |        | Provider NPI:               |                  |
| Referring Practice Name:               |        | Phone:                      | Fax:             |
| Practice Address:                      |        | City:                       | State: Zip Code: |
| Physician Preferred Method of Contact: | Email: | Fax:                        | Phone:           |

## STANDING ORDERS

Infusion to be administered per Vivo protocols.

## LABORATORY ORDERS

CBC w/ diff every \_\_\_\_\_  
CMP every \_\_\_\_\_  
OTHER \_\_\_\_\_

## PREMEDICATIONS

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: \_\_\_\_\_

## SPEVIGO ADMINISTRATION

900 mg IV over 90 minutes  
*If flare symptoms persist, an additional 900 mg dose of Spevigo may be administered one week after the initial dose. If needed, please submit a separate order form for this dose*  
600 mg SQ, then 300 mg SQ every 4 weeks  
  
300 mg SQ every 4 weeks (for patients that have received 900 mg IV dose 4 weeks prior)

## REQUIRED DOCUMENTATION

- Patient Demographics
- Insurance Card/Information
- Progress Notes Supporting DX
- Current Medication List and H&P
- Negative TB test or CXR within the last 12 months

\*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions.

Provider Name (Print) Provider Signature Date

|  |                             |                          |   |                         |
|--|-----------------------------|--------------------------|---|-------------------------|
| <b>Email Referrals To: <a href="mailto:referrals@vivoinfusion.com">referrals@vivoinfusion.com</a> OR Fax Below</b> |                             |                          | <b>Have a Question? Call (720) 902-4111</b> |                         |
| Colorado: 303-418-4679   | Massachusetts: 781-202-1629 | New Jersey: 609-955-3711 | Oklahoma: 918-770-4421                      | Virginia: 804-500-5941  |
| Connecticut: 203-724-4838  | Michigan: 833-957-2188      | New York: 800-540-1852   | Pennsylvania: 215-399-9244                  | Wisconsin: 414-600-5383 |
| Florida: 904-930-4211  | Minnesota: 763-290-0903     | Ohio: 216-400-0674       | Texas: 469-340-0044                         |                         |

\*\*Order is valid for one year unless otherwise noted.\*\*

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