Spevigo (spesolimab-sbzo)

Provider Order Form *rev. 1/12/2026*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ L40.1 Generalized pustular psoriasis ☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.

☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Negative TB Results
☐ Other: _____

Spevigo (spesolimab-sbzo) Administration (Select one):

☐ Infuse 900 mg IV once
☐ 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)

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454