Spevigo

INFUSE ONE OHIO

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB Test

PATIENT INFORMATION

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

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ L40.1 ICD Description:

Allergies: Weight (lbs/kg): Height:

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

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Treatments follow Infuse One Ohio's established infusion and injection protocols.

☑ TB Status and Date (list results & attached clinicals): _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____ ☐ Frequency: _____

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

☑ Spevigo Intravenous Infusion

Dose: ☑ 900mg x 1 dose

If flare symptoms persist, an additional intravenous 900mg dose may be administered one week after the initial dose. New Order Required.

Subsequent treatments may require additional insurance authorization.

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

Provider Name (Print) _____ Provider Signature _____ Date _____

☐ ***Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***