Local Infusion

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# SPEVIGO (SPESOLIMAB-SBZO) ORDER FORM

## PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments: _____

❑ New Start Therapy | ❑ Continuation of Therapy & Date of last dose (if applicable): _____

## DIAGNOSIS (Provider must specify)

❑ Generalized Pustular Psoriasis: L40.1 _____

❑ Other: _____

## PROVIDER INFORMATION

Provider Name (print name): _____ Provider NPI: _____

Signature: _____ Date: _____

Contact Name: _____ Phone: _____ Fax: _____

Email Address: _____

**Prerequisites to treatment –** ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

## PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

## MEDICATION

| MEDICATION | DOSE | ROUTE | FREQUENCY |
|---|---|---|---|
| Spevigo | 900 mg. x 1, May repeat 900 mg. dose in one week with persistent flare. | IV | ❑ x 1 initial dose<br>❑ x 1 repeat dose |

## LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____

**FAX NUMBERS:**

❐ CT: 203.433.0621
❐ FL: 904.877.9270
❐ MA: 413.296.8482
❐ MD: 240.224.8607
❐ ME: 207.407.7272
❐ NC: 919.984.8698
❐ NH: 603.217.5371
❐ NJ: 201.581.4521
❐ NY: 631.250.6020
❐ OH: 937.871.4594
❐ PA: 610.273.5998
❐ SC: 864.973.6279
❐ VA: 703.202.0499