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

INDICATION	DOSE	ROUTE	FREQUENCY
Treatment of GPP Flare	900mg	IV	❑ 1 time dose ❑ Additional 900 mg dose 1 week later, if flare symptoms persist
Treatment of GPP when not experiencing a flare	❑ Loading Dose 600mg ❑ Maintenace Dose 300mg	Subcutaneous Inj.	❑ Once ❑ Start 4 weeks after loading dose, then every 4 weeks thereafter
SC maintenance following IV treatment for a GPP flare	300mg	Subcutaneous Inj.	❑ Start 4 weeks after IV treatment, then every 4 weeks; no SC loading dose required; if more than 4 weeks have relapsed since IV treatment, use standard SC initiation with a 600mg loading dose

LABS / SPECIAL INSTRUCTIONS