medix infusion

Spevigo Order Form
(spesolimab-sbzo)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: ______________________________

DOB: ______________ Phone: ______________ Sex: M F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

L40.1 Generalized pustular psoriasis

Other: ______________________________

Patient Status:

New to therapy

Continuing therapy (date of last dose __________)

Weight: __________ lb kg Height: __________

Allergies: ______________________________

PRESCRIPTION

SPEVIGO (spesolimab-sbzo)

Infuse 900 mg IV once

Please resubmit a new order form for repeat dose with additional required documentation

Is the patient on any other disease modifying therapy? Yes No

Is yes, please note therapy and last dose: ______________________________

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol.

Other Orders: ______________________________

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting/labs diagnostics:

Negative TB within 12 months

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

Signature: ______________________________

NPI #: ______________ Date: ______________

Supervising Physician (if applicable): ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip: ______________

Contact Name: ______________ Phone: ______________ Fax: ______________