Spevigo Order Form
(spesolimab-sbzo)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code

☐ L40.1 Generalized pustular psoriasis

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative Hepatitis TB within 12 months.**

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
Other: _____

Lab Orders+

Required: Negative TB

+ Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider

SPEVIGO (spesolimab)

Loading Dose

IV: Infuse 900 mg in 100 mL of 0.9% Sodium Chloride over 90 minutes via pump with 0.2-micron filter

☐ Repeat dose 7 days following initial dose if flare persists

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**
If yes, please note therapy and last dose: _____

Post Treatment Observation: The patient is observed for 30 minutes following the first administration.

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

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

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