

SPEVIGO (SPESOLIMAB-SBZO) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____
 Mobile Number: _____ Patient Weight: _____
 Allergies: _____

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 Famotidine 20 mg IV Methylprednisolone (Solu-Medrol) 125 mg IVP
 Benadryl 25mg PO Cetirizine (Zyrtec) 10 mg PO
 Other: _____ Dose: _____ Route: _____

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Spevigo	<input type="checkbox"/> 900 mg x 1 (may repeat 900 mg dose in one week with persistent flare) New order will be required for repeat dose	<input type="checkbox"/> IV	<input type="checkbox"/> x 1 initial dose <input type="checkbox"/> x 1 repeat dose

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

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: NH: 603.217.5371 ME: 207.407.7272

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