# Spevigo
(spesolimab)

Advanced Infusion Care Centers

## PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

## PRIMARY DIAGNOSIS

☐ L40.1 Generalized pustular psoriasis (GPP)

☐ Other: _____

## PRESCRIPTION

**IV**

☐ Spevigo 900mg IV over 90 minutes as a single dose for the treatment of GPP flare, may repeat dose one week after initial dose if symptoms persist

**Subcutaneous** (4 weeks after IV dose)

☐ Spevigo 300mg subQ every 4 weeks x 1 year

**Subcutaneous** (treatment of GPP when not experiencing a flare)

☐ Spevigo 600mg subQ as a loading dose followed by 300mg subQ 4 weeks later and every 4 weeks thereafter x 1 year

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

## REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Negative TB test within past 12 months

## ANCILLARY ORDERS

### ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol.
*(See aiscaregroup.com for detailed policy)*
- Epinephrine (weight-based dosing) PRN per protocol

☐ Other: Please fax other reaction orders if checking this box

### PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended standard pre-meds for Spevigo

☐ Provider Prescribed: _____

### LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*