MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB: _____

Standard Plan of Treatment for Spevigo® (spesolimab-sbzo)

NOTE: Patient ***may be ineligible*** to receive spesolimab-sbzo if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, and/or surgery.

1. **Patient Name**: _____Height (in.):_____ Weight (lbs):_____
2. **Allergies**: _____
3. **Diagnosis:**

☐ L40.1 Generalized pustular psoriasis ☐ Other_____

4. **Pre-medication:** ***Administered 30 minutes prior to infusion as selected:*** ***For Infusions**

Acetaminophen:
- ☐ 1000mg PO
- ☐ 650mg PO
- ☐ 500mg PO
- ☐ 325mg PO

Diphenhydramine: ☐ 25 mg PO ☐ 50 mg PO ☐ 25 mg IV ☐ 50 mg IV *or*

Fexofenadine: ☐ 60mg ☐ 180 mg *or* ☐ Cetirizine 10 mg *or*

☐ Loratadine 10 mg

Methylprednisolone: ☐ 40 mg IV ☐ 125 mg IV or other_____mg IV

Famotidine: ☐ 20 mg PO ☐ 40 mg PO ☐ 20 mg IV ☐ 40mg IV

5. **Order:**

☐ **Spevigo® 900mg/100ml NS infusion x 1 single dose**

☐ **For persistent symptoms administer an additional dose Spevigo® 900mg/100ml NS IV infusion 1 week after initial dose**

Administer as an intravenous infusion over 90 minutes using a 0.2 micron filter

6. **Special Order:** _____

Lab orders with infusion: _____

7. **Physician's Signature**:_____/_____ **Date**: _____
(Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

Created 09/22/2022

8. ***Fax updated supporting clinical MD notes with each order renewal or change in orders***

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.accurxinfusion.com

MRN:_____
DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

Guidelines for Prescribing Spevigo® (spesolimab-sbzo)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-8)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.AccuRXinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

☐ Do not administer live vaccines concurrently with Spevigo®

☐ Other as requested: _____
_____

Required Pre-Screening:

☐ **TB screening test completed. Results** (positive or negative): _____

Warnings & Precautions

Infections: SPEVIGO may increase the risk of infections. Do not initiate SPEVIGO during any clinically important active infection. Instruct patients to seek medical advice if signs or symptoms of clinically important infection occur after treatment with SPEVIGO. (5.1)• Tuberculosis (TB): Evaluate patients for TB prior to initiating treatment with SPEVIGO. (5.2)• Hypersensitivity and Infusion-Related Reactions: Hypersensitivity including drug reaction with eosinophilia and systemic symptoms (DRESS) and infusion-related reactions may occur. If a serious hypersensitivity reaction occurs, discontinue SPEVIGO immediately and initiate appropriate treatment. (5.3)• Vaccinations: Do not administer live vaccines concurrently with SPEVIGO. (5.4)

AccuRX Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.