Referral Status:		MRN:	
☐	New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:			

Spevigo® (spesolimab-sbzo) Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:			Patient's Phone:				
Patient Name:			Address:				
Date of Birth:			City, State, Zip:				
Height in inches:	Weight: LB or KG		Gender:	Allergies:	☐	See list ☐	NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐ L40.1 - Generalized pustular psoriasis

☐ _____ - Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
6			

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	◯	25mg	◯	50mg				
	Methylprednisolone	◯	40mg	◯	125mg	◯	Other:		
	Famotidine	◯	20mg	◯	40 mg				
	Other:	◯							

PO	Acetaminophen	◯	325mg	◯	500mg	◯	650mg	◯	1000mg
	Famotidine	◯	20mg	◯	40mg				
	Diphenhydramine	◯	25mg	◯	50mg				
	Fexofenadine	◯	60mg	◯	180mg				
	Cetirizine	◯	10mg						
	Loratadine	◯	10mg						
	Other:	◯							

MEDICATION:

☑ Spevigo® 900mg/100ml NS infusion

FREQUENCY:

◯ One time dose

◯ Follow up dose 1 week after intial dose

◯ Other: _____

SPECIAL/LAB ORDERS:

◯ _____

_____

☑ Refills:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023