

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX:  M  F HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  LBS  KG

ALLERGIES: \_\_\_\_\_ PREFERRED CLINIC: \_\_\_\_\_

REFERRAL STATUS:  NEW REFERRAL  ORDER CHANGE  ORDER RENEWAL

**DIAGNOSIS & CLINICAL DOCUMENTATION**

L40.1 Generalized pustular psoriasis

ICD-10 CODE: \_\_\_\_\_ DESCRIPTION: \_\_\_\_\_

**REQUIRED DOCUMENTATION**

Insurance Information

List of Medications

Most Recent History & Physical

Tried & Failed Therapies

Negative TB screening within 12 months

**MEDICATION ORDER**

Spevigo® (spesolimab) 900mg IV in 100ml NS over 90 minutes

Repeat dose 1 week after initial dose

**PRE-MEDICATIONS**

**PO**

Acetaminophen: 650 mg

Cetirizine: 10 mg

Diphenhydramine: 25 mg

**IV**

Methylprednisolone: 125 mg

Diphenhydramine: 25 mg

**OTHER:** \_\_\_\_\_  PO  IV

Patient to be observed for 30 minutes following the first administration. Administer per protocol. In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

**PRESCRIBER INFORMATION**

PROVIDER NAME: \_\_\_\_\_ NPI #: \_\_\_\_\_

EMAIL: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

ADDRESS (INCLUDE CITY, STATE, ZIP): \_\_\_\_\_

SUPERVISING PHYSICIAN: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
(IF APPLICABLE)

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN