INTRAMED Plus
infusion services

SPEVIGO®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Pleasecomplete/select appropriate primary diagnosis):

Primary Diagnosis: _____ Generalized pustular psoriasis (GPP) ICD-10 Code: L40.1

_____ Other:_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical notes supporting primary diagnosis
- Recent Lab Results including Tuberculosis (TB) test
- Medication List

Patient
Weight: _____ lbs.
Height:_____ in.

SPEVIGO® (spesolimab-sbzo) J Code: J1747

4. Drug Order:

Administer 900 mg IV over 90 minutes for one infusion Doses Authorized: One (2*450 mg vials)

If flare symptoms persist, an additional 900 mg dose may be administered one week after the initial dose. If necessary, please submit a new order form for this dose

Pre-Medication Orders: Acetaminophen 650 mg PO and Diphenhydramine 25 mg PO
Administered 30 min prior to infusion *Adjust to patient's needs

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

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

FAX ALL INFORMATION CENTRAL FAX **803.999.1754**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**