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 (Please select primary diagnosis and complete ICD-10 Code):

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 documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o Tuberculosis (TB) screening results
- Medication List

Patient
Weight: _____ lbs.
Height: _____ in.

4. Drug Order:

SPEVIGO® (spesolimab-sbzo) J Code: J1747

Treatment of Flare (intravenous)	Treatment <u>without</u> Flare (<u>subcutaneous</u>)
❑ Infuse 900 mg intravenously over 90 minutes once **Doses Authorized:** one (2*450 mg vials) *If flare symptoms persist, an additional 900 mg IV dose may be administer one week after the initial dose. If needed, please submit a new order form for this dose. Or Four weeks after treatment with IV Spevigo, initiate or reinitiate subcutaneous at a dose of 300 mg (two 150 mg injections) administered every 4 weeks. A loading dose is not required following treatment of a GPP flare with IV Spevigo. If needed, please check 'maintenance dose'.	❑ **Loading Dose:** Inject 600 mg (four*150 mg injections) subcutaneously at week 0, followed by 300 mg every 4 weeks thereafter. **Doses authorized:** one (4*150 mg PFS) ❑ **Maintenance Dose*:** Inject 300 mg (two*150 mg injections) subcutaneously every 4 weeks. **Doses Authorized:** 12 or _____ * The maintenance dose is for patients who have received the subcutaneous loading dose or who have been previously treated with IV Spevigo. For patients previously treated with IV Spevigo, the subcutaneous dose should be administered 4 weeks after the intravenous dose.

Pre-Medication Orders: _____

No Pre-medications are recommended based on manufacturer guidelines.

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

By signing this form and utilizing our 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: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**