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** COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760

MAR 2023