

## Spevigo® IV (Intravenous) Referral Form

**\*\*Attach Demographic Information & Insurance Cards (front/back copies) if needed\*\***

|  |                    |                           |   |
|--|--------------------|---------------------------|---|
| Patient Name:  |                    | DOB:                      | Gender:   |
| Address:   |                    | Primary Phone:            |   |
| City:  | State:             | Zip:                      | Alt Phone:  |
| Email:   |                    | SSN# (last 4 # required): |   |
| Weight (required):   | Height (required): | ft                        | in  |
| Home Medication List Attached: <input checked="" type="checkbox"/> |                    |                           |   |
| <input checked="" type="checkbox"/> NKA Allergies:                 |                    |                           | <input checked="" type="checkbox"/> Allergy list attached |

### Diagnosis & Clinical Documentation ICD-10 Code:

\*

**\*\* Please attach CLINICAL PROGRESS NOTES, TESTS, LABS, HISTORY OF ATTEMPTED/FAILED TREATMENTS to support diagnosis & treatment\*\***

|  |  |
|--|--|
| <input checked="" type="checkbox"/> Generalized pustular psoriasis (GPP) | <input checked="" type="checkbox"/> Negative TB Screening (REQUIRED) |
| Other:   |  |

| Premedication(s) given 30 minutes prior to treatment:  |  | Ancillary Orders as per Protocol              |
|--|--|---|
| <input checked="" type="checkbox"/> Acetaminophen _____ mg PO  | <input checked="" type="checkbox"/> Diphenhydramine _____ mg <input checked="" type="checkbox"/> PO <input checked="" type="checkbox"/> IV | * Infusion Supplies as required               |
| <input checked="" type="checkbox"/> Cetirizine 10mg PO   | <input checked="" type="checkbox"/> Methylprednisolone _____ mg IV   | * Start Peripheral IV/Access VAD as required. |
| <input checked="" type="checkbox"/> Fexofenadine <input checked="" type="checkbox"/> 60mg <input checked="" type="checkbox"/> 180mg PO | <input checked="" type="checkbox"/> Famotidine _____ mg <input checked="" type="checkbox"/> PO <input checked="" type="checkbox"/> IV      | * NaCl 0.9% flushing/locking as required      |
| <input checked="" type="checkbox"/> Loratadine 10mg PO   |  | * Heparin flushing/locking as required        |

### Prescription Information ☒ Refills x 12 months unless otherwise noted here:

| Medication                           | IV (Intravenous) Dosing and Frequency for Treatment of GPP Flare   | Standard Protocol   |
|--------------------------------------|--|---|
| <b>Spevigo®</b><br>(spesolimab-sbzo) | <input checked="" type="checkbox"/> Spevigo (spesolimab-sbzo) 900mg/100mL NS IV to infuse over 90 minutes<br><b>Frequency</b><br><input checked="" type="checkbox"/> One time single dose<br><input checked="" type="checkbox"/> If flare symptoms persist, repeat second dose 1 week after initial dose | Dilute in 100mL NS over 90 minutes. Infusion should not exceed 180 minutes. |

Specify past/current treatments attempted/failed:

Clinical Lab Orders: Frequency:

|                                 |   |
|---------------------------------|---|
| Additional Orders/Instructions: | <b>Anaphylaxis &amp; Adverse Reaction Orders</b>  |
|                                 | *Administer anaphylaxis medications as per the Standing Adverse Reaction Protocol provided by Vital Care of Florence, access on our website or via QR code.  |

### Physician Information

|                   |                   |            |
|-------------------|-------------------|------------|
| Prescriber Name:  | DEA#:             | License #: |
| Name of Practice: | Office Contact:   |            |
| Address:          | City, State, Zip: |            |
| Phone #:          | Fax #:            | Email:     |

I authorize Vital Care Infusion Services, LLC and its representatives to initiate any insurance prior authorization process that is required for this prescription and for any future refills of the same prescription for the patient listed above which I order. I understand that I can revoke this designation at any time by providing written notice to Vital Care.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ NPI#: \_\_\_\_\_

**Prescriber must MANUALLY SIGN- Stamped signatures, signature by other personnel, & computer generated signatures will not be accepted.**

The attached document(s) contains confidential information which may be considered PROTECTED HEALTH INFORMATION & therefore required to be maintained as private & secure under HIPAA. The documents may also contain information which is otherwise considered to be privileged under state & federal law. This communication is for the intended recipient only. If you are not the intended recipient, or a person responsible for delivering this communication to the intended recipient, you are prohibited from viewing, copying, and/or distributing the information contained herein. Unlawful disclosure of the information attached may subject you to monetary penalties and sanctions. If you have received this communication in error, you should notify the sender immediately and thereafter permanently destroy all copies of this document in its entirety. This form is not considered an order or prescription for medical services and/or supplies unless and until it is formally authorized by a healthcare provider in compliance with applicable laws and regulations. Revised 12/9/24

