vitalcare INFUSION SERVICES of FLORENCE

Pharmacy Name: **Vital Care of Florence**
Address: **161 Dozier Blvd, Suite 100**
City/State/Zip: **Florence, SC 29501**

Phone: **843-954-0010**
Fax: **843-954-0011**
Email: **info@vcflorence.com**

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: ☐

☐ NKA Allergies: ☐ 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**

☐ Generalized pustular psoriasis (GPP)
Other:

☐ Negative TB Screening **(REQUIRED)**

Premedication(s) given 30 minutes prior to treatment:

☐ Acetaminophen _____ mg PO
☐ Cetirizine 10mg PO
☐ Fexofenadine ☐ 60mg ☐ 180mg PO
☐ Loratadine 10mg PO
☐ Diphenhydramine _____ mg ☐ PO ☐ IV
☐ Methylprednisolone _____ mg IV
☐ Famotidine _____ mg ☐ PO ☐ IV

Ancillary Orders as per Protocol

* Infusion Supplies as required
* Start Peripheral IV/Access VAD as required.
* NaCl 0.9% flushing/locking as required
* 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
Spevigo® (spesolimab-sbzo)	☑ Spevigo (spesolimab-sbzo) 900mg/100mL NS IV to infuse over 90 minutes Frequency ☐ One time single dose ☐ 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:

Anaphylaxis & Adverse Reaction Orders

*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.

 Revised 12/9/24