



SPEVIGO MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ Patient's weight in pounds _____

■ Diagnosis

L40.1 Generalized pustular psoriasis

■ Details Needed for Approval

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Please provide documentation of a current generalized pustular psoriasis (GPP) flare of moderate to severe intensity.
- What is the patient's GPPPGA total score? _____ Pustulation sub-score? _____ *Please provide supporting documentation.*
- Does the patient have presence of fresh pustules, or newly worsening pustules? _____
- Is at least 5% of the patient's body surface area covered with erythema and the presence of pustules? _____
- Does the patient have any active clinically-important infections? _____
- Has the patient been instructed not to get any live vaccines concurrently with Spevigo? _____
- Will the patient concomitantly use systemic immunosuppressants (such as methotrexate)? _____
- Will the patient concomitantly use topical agents (such as steroids or tacrolimus)? _____
- Will the patient concomitantly be treated with a TNF-inhibitor, biologic or non-biologic for GPP? _____
- Does the patient have Synovitis-acne-pustulosis-hyperostosis-osteitis (SAPHO) syndrome, primary erythrodermic psoriasis vulgaris, primary plaque psoriasis or drug-triggered acute generalized exanthematous pustulosis (AGEP) ?
If Yes, please circle all conditions that the patient has.

■ Medication Order

Spevigo (spesolimab-sbzo) 900mg by IV, one time only.

Spevigo (spesolimab-sbzo) 900mg by IV, once, with a second treatment after 1 week if the GPP flare persists.

Medication shall be added to a 100ml NS infusion bag after 15ml has been removed. Mix gently. Infuse over at least 90 minutes with a 0.2 micron in-line filter. Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms throughout.

■ Rescue Management in case of Infusion Therapy Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including diphenhydramine, methylprednisolone, and oxygen as needed. Administer albuterol sulfate 2.5ml by nebulizer for wheezing and respiratory reactions. Administer famotidine 20mg IV-push for minor cutaneous reactions which do not respond to diphenhydramine.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.