

**Patient Information**

Patient Name:		DOB:	
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable): _____			
Is the patient pregnant, planning a pregnancy or nursing:		Yes	No
Does the patient need interpreter services:		Yes	No

**Provider Information**

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip:

**ICD-10 CODE**

L40.1 Generalized pustular psoriasis      Other: \_\_\_\_\_

**Medication Order**

**Spevigo** (spesolimab-sbzo)

**Dose and frequency:** 900mg IV once

**Note:** If flare symptoms persist, an additional 900 mg dose of Spevigo may be administered one week after the initial dose. If needed, please submit a separate order for this dose.

**Documentation Required (Note: Send all labs, must include specific labs listed here)**

Labs (TB)      Insurance Card (front and back)      Current Medications      History/Progress Notes

**Pre-Medication Order**

<b>acetaminophen</b> (Tylenol)	500mg	650mg	1000mg PO	<b>diphenhydramine</b> (Benadryl)	25mg	50mg /	PO	IV
<b>cetirizine</b> (Zyrtec)	10mg PO			<b>methylprednisolone</b> (Solu-Medrol)	40mg IV	125mg IV		
<b>loratadine</b> (Claritin)	10mg PO			<b>hydrocortisone</b> (Solu-Cortef)	100mg IV			
<b>ondansetron</b> (Zofran)	4mg	8mg /	PO	IV				

Other: \_\_\_\_\_

Dose: \_\_\_\_\_      Route: \_\_\_\_\_      Frequency: \_\_\_\_\_

**Special Instructions (Prior therapy, treatment dates, and reasons for d/c)**

**Provider Name**

**Provider Signature**

**Date**

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.

Check here if this is a stat order

**Patient Information**

Patient Name:	DOB:	Sex: M F	Fasting: Y N
Patient Home Phone:	Patient Cell Phone:	Patient Email:	
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	

**Lab Test (Please circle or write in ICD-10)**

ALT R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	HIV VIRAL LOAD Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20
AST R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgE J45.4, J45.3, L50.9, J45.40, J45.50
HEPATIC FUNCTION PANEL R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21	IgG G35, G36.0
BASIC METABOLIC PANEL I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9	IMMUNOGLOBULIN QUANT IgG, IgM, IgA G35, G36.0
CALCIUM M81.0, M81.8	IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE G35, G36.0
CBC (INCLUDES DIFF/PLT) I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1	IRON, TIBC, FER PNL D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
CBC (H/H, RBC, WBC, PLT)s I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1	LIPID PANEL Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2
COMP METABOLIC PANEL I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9	MAGNESIUM I10, Z79.899, R25.2, E83.42, Z00.00
CREATININE M81.0, M81.8, G35	PSA R97.20, C61, N40.1, Z12.5, N40.0
C-REACTIVE PROTEIN (CRP) R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50	PROTHROMBIN TIME-INR Z79.01, I48.91, I48.0, Z51.81
FERRITIN D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9	TRANSFERRIN SATURATION D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9
G6PD M1A.9XX0, M1A.9XX1	QUANTIFERON TB GOLD Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90
GROWTH HORMONE E22, C7A.1, E34	TSH E03.9, I10, E03.8, R53.83, E06.3, E05.00
HBSAG CONFIRMATION Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	URIC ACID M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1
HEMOGLOBIN & HEMATOCRIT D50.9, D64.9, D50.0, D63.1, N18.9	VIT B12/FOLIC ACID M89.49, E53.8, R53.83, F41.8, F41.9, E05.00
HEMOGLOBIN A1C E11.9, E11.65, R73.01, Z00.00, I10	VIT D 25- HYDROX E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8
HEP B SURF AG Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0	Miscellaneous Labs Not Listed (Write In)
HIV 4TH GEN Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20	
HIV 1/2 AB DIFF Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20	

**Frequency**

Prior to each dose	Yearly	Other: Please Specify Below
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	
Lab Test: _____	Frequency: _____	

Provider Name	Provider Signature	Date
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Provider Phone