ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Spesolimab-sbzo (Spevigo)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis: ❑ Pustular Psoriasis

ICD -10 Code:
❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

Baseline labs required:

- Latent TB testing Date _____ / _____ / _____ Results:_____

* Patients should be up to date with all immunizations before initiating therapy. Avoid the use of live vaccines in patients undergoing Spesolimab-sbzo treatment

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Treatment Regimen:

❑ Spesolimab-sbzo (Spevigo) 900 mg IV infusion over 90 minutes; if flare persists, an additional 900 mg IV may be given one week later

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contract provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4C)

If hypersensitivity develops (fever, chills, hyptension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
PUSTULAR PSORIASIS

MultiCare

60-0199-5 (3/23)