

**ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN**

**Allergies/Reactions:**

Fax all infusions to: 833-380-8800  
Please mark the appropriate  
infusion center:

- Allenmore Infusion Center
- Auburn Infusion Center
- Gig Harbor Infusion Services
- Puyallup Infusion Center
- DHEC Infusion Center
- North Spokane Infusion Center
- North Star Lodge Infusion Center

**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

**ICD -10 Code:**

**Diagnosis:**  Pustular Psoriasis  \_\_\_\_\_

**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**

