BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: _____ Date of Last Infusion: _____
Height _____ Weight _____ Infusion Location: (state and site) _____

Spevigo® (spesolimab-sbzo) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Generalized Pustular Psoriasis _____ Other _____

- Hold infusion and notify provider for:
  - Signs or symptoms of illness or active infection
  - Planned/recent surgical procedures or recent live vaccines
- Measure and record weight at each appointment
- If infusion-related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Protocol as clinically indicated

Documentation Required:

- Treatment Failures
- TB/Hepatitis B results or vaccination
- Office visit notes with treatment progression

Lab orders:

☐ Other: _____

Dosing: Current Weight:

Administer Spevigo 900mg IV one time over 90 mins in 100ml NS thru in IV line with in line filter (0.2micron)
Must complete infusion in 180mins

☐ May repeat dose one additional time in 1 week if flare persist

Additional Orders:

_____

_____

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 4/24/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.