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SPEVIGO (Spesolimab-sbzo) Infusion Orders

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Gender: _____ Height: _____ Weight: _____ (lb./kg)

Diagnosis

☐ _____ Generalized Pustular Psoriasis ☐ _____

Pre-Medication

☐ Tylenol 500mg/650mg PO ☐ Solu-Medrol 125mg IVP
☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg/50mg IVP
☐ Diphenhydramine 25mg/50mg PO ☐ _____
☐ Solu-Medrol 40mg IVP ☐ _____

Orders

Dosage

☐ __900__ mg I.V. one time over 90 minutes in 100 ml NS

Frequency

☐ Single dose ☐ May repeat one dose an additional time in 1 week if flare persists

Notes

Ordering Provider

Signature: _____ Date: _____
Provider: _____ Phone: _____ Fax: _____
Address: _____
NPI: _____ DEA: _____