



**Atrium Health Infusion  
Center**

Referral Status:	<input type="checkbox"/> New Start <input type="checkbox"/> Order Change <input type="checkbox"/> Renewal
Preferred Location:	<input type="checkbox"/> Atrium Health Infusion Center Concord <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Pineville <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Southpark <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Huntersville <b>Fax: 704-468-3401</b> <input type="checkbox"/> Atrium Health Infusion Center Kenilworth, a facility of CMC <b>Fax: 704-512-5390</b> <input type="checkbox"/> Atrium Health Infusion Center Abbey Place, a facility of CMC <b>Fax: 704-512-5390</b> <input type="checkbox"/> Atrium Health Infusion Center Cabarrus, a facility of CMC <b>Fax: 704-512-5390</b>

**Spevigo® (spesolimab-sbzo) Infusion Order** (Revised 11/7/2025)

All orders with a √ will be placed.

<b>Patient Demographics:</b>		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) <input type="checkbox"/> NKDA		
<b>Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)</b>		
<input type="checkbox"/> L40.1 - Generalized Pustular Psoriasis		<input type="checkbox"/> Other:
<b>Required Documentation: (required prior to scheduling )</b>		
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:  <input type="checkbox"/> No Washout Needed	
Copy of Insurance Card (front and back)		
Most Recent Labs ( <i>must include labs pertinent to medication ordered</i> )	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:  If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.  <input type="checkbox"/> Yes <input type="checkbox"/> No	
Consult Note or last 2 Office Visits with referring provider or APP		
Complete Medication List - Include all tried and failed meds		
Diagnostic Studies Pertinent to Medication Ordered		
<b>Treatment Parameters</b>		
Hold treatment and notify provider IF: <input checked="" type="checkbox"/> - Temperature is GREATER THAN 100oF; <input type="checkbox"/> - Patient complains of symptoms of acute viral or bacterial infection; <input type="checkbox"/> - Patient is taking an antibiotic for current infection.		
Required lab results: PPD/Quatiferon Gold PRIOR to first treatment. ( <b>fax labs with order</b> ) <input checked="" type="checkbox"/> - Hold Tx and Notify Provider IF: <input type="checkbox"/> - PPD/Quantiferon Gold: POSITIVE result or not on file.		
<b>Nursing Communication:</b>		
<input checked="" type="checkbox"/> Start PIV/Access CVC and flush device per approved Atrium Health protocol.		
<input checked="" type="checkbox"/> Obtain vital signs every 15 minutes during infusion and more frequently if signs of adverse reactions are suspected.		
<input checked="" type="checkbox"/> Monitor post infusion BP 30 minutes after completion of infusion.		
<b>Pre-Medications:</b>		
<input type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg PO ONCE		
<input type="checkbox"/> Diphenhydramine (Benadryl) 25mg IV ONCE		
<input type="checkbox"/> Loratadine (Claritin) 10mg PO ONCE		
<input type="checkbox"/> Methylprednisolone Sodium Succinate (Solu-Medrol) 125mg IV ONCE		
<b>Infusion Therapy:</b>		
Spesolimab-sbzo (Spevigo) 900mg IV over 90 minutes ONCE - Flush IV line with 0.9% sodium chloride prior to infusion <input checked="" type="checkbox"/> - Administer through an IV line containing a sterile, non-pyrogenic low protein binding in-line filter (0.2 micron) - Total infusion time should not exceed 180 minutes - Flush IV line with 0.9% sodium chloride after infusion is complete.		
<b>Supportive Care Medications:</b>		
<input checked="" type="checkbox"/> Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.		
<input checked="" type="checkbox"/> Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.		
<input checked="" type="checkbox"/> Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.		
<b>Hypersensitivity Protocol:</b>		
<input checked="" type="checkbox"/> Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.		
<b>Prescriber Information:</b>		
Provider Name:	Phone:	Fax:
Practice Name:	NPI:	
Address:	Office Contact:	
City, State, Zip:	Office Contact Phone Number:	
<b>Physician Signature: (Order expires 12 months from date of signature ) No Stamp Signatures Accepted</b>		
Signature:	Date:	