Spesolimab-sbzo (Spevigo)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy	☐ Continuing Therapy - Last Treatment Date:		Next Due Date:
PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
DIAGNOSIS AND ICD 10 CODE			
☐ Generalized pustular psoriasis (GPP)	ICD10 : L40.1		
☐ Other:	ICD10:		
REQUIRED DOCUMENTATION/Testing			
☐ This signed order form by the provider ☐ Patient demographics AND insurance info ☐ Clinical/Progress notes supporting primary dx	☐ TB Test result		
List Tried & Failed Therapies 1)	2)		
MEDICATION ORDERS			
☐ Spevigo 900 mg IV x1 dose			

SPECIAL INSTRUCTIONS

Provider Name (Print) ****Physician Signature:** **Date:**

Fax referral to 866-507-1164 or email to MICreferral@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.

Created 1/27/23