Please fax all pages of completed form to your team at 888.302.1028.

To reach your team, call toll-free 844.516.3319.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Spevigo® (spesolimab-sbzo)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Shipment location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line.

If patient's home, please check one if order includes loading dose:

☐ Home Health Nursing will administer loading ☐ Prescriber's office will administer loading

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

ADMINISTRATION LOCATION: ☐ Patient's home ☐ Healthcare facility

Medication	Strength/ Formulation	Directions	Quantity/Refills	Ship To
Spevigo® (spesolimab-sbzo)	**Treatment of Flare (Intravenous)**			
	450mg/7.5mL vial	☐ Infuse 900mg (Two 450mg single dose vials) Intravenously once over 90 minutes	2 vials Refill (Max 1 refill) _____	Note: The intravenous dose must be administered in a healthcare setting. ☐ Office ☐ Infusion Clinic ☐ Unknown (Please assist with finding Infusion Site.)
	Treatment When Not Experiencing a Flare (Subcutaneous)			
	150mg/mL pre-filled syringes	**Loading Dose:** ☐ Inject 600mg (four 150mg injections) subcutaneously at week 0, followed by 300mg (two 150mg injections) every 4 weeks thereafter. ☐ Patient does not need loading dose.	28-day supply No Refills	☐ Office ☐ Home Note: Loading dose must be administered by a Healthcare Provider. If shipping to patient's home, please check one: ☐ Training/Administration to be provided by Healthcare Provider in office. ☐ Training/Administration needed by Nursing in home.
		Maintenance Dose: ☐ Inject 300mg (two 150mg injections) subcutaneously every 4 weeks. The maintenance dose is for patients who have received the subcutaneous loading dose or who have been previously treated with intravenous Spevigo. For patients previously treated with intravenous Spevigo, the subcutaneous dose should be administered 4 weeks after the intravenous dose.	28-day supply Refills _____	☐ Home Please check one: ☐ Training/Administration needed by Nursing in home. ☐ Patient will self-administer and does NOT need training from Nursing.
Hypersensitivity/Anaphylaxis (For subcutaneous Loading Doses administered in the home) Medicate with: Epinephrine/EpiPen 0.3mg IM as needed for anaphylaxis ☐ Other _____			Send quantity and refills sufficient for medication days supply.	
☐ Skilled nursing visit for education for self-administration, medication administration and assessment of general status and response to therapy.				

Dispense needles, syringes, ancillary supplies and home medical equipment necessary to administer medication.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Prescriber's signature required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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