Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Spevigo Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (856) 996-0145
F. (856) 770-8271 ~ Attn: Stephanie D

Is this a Continuation of Care or a new start to the medication?

- ▢ Continuation of Care (Provide documentation of last administration)
- ▢ New Rx

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Email of Contact	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY _____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	▢ Voorhees ▢ Moorestown ▢ Wall/Manasquan ▢ Sewell ▢ Hamilton ▢ Galloway

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

Diagnosis:
☐ L40.1 Generalized pustular psoriasis

The following information is required for authorization for persistent generalized pustular psoriasis:

- Proof of patient's negative latent TB test. If the test is positive, proof that the patient has begun therapy for latent TB.
- Please provide documentation of a current generalized pustular psoriasis (GPP) flare of moderate to severe intensity.
- What is the patient's GPPPGA total score? _____
- Pustulation sub-score? _____ Please provide supporting documentation.
- Does the patient have the presence of fresh pustules, or newly worsening pustules? _____
- Is at least 5% of the patient's body surface area covered with erythema and the presence of pustules? _____
- Does the patient have any active clinically-important infections? _____
- Has the patient been instructed not to get any live vaccines concurrently with Spevigo? _____
- Will the patient concomitantly use systemic immunosuppressants (such as methotrexate)? _____
- Will the patient concomitantly use topical agents (such as steroids or tacrolimus)? _____
- Will the patient concomitantly be treated with a TNF-inhibitor, biologic or non-biologic for GPP? _____
- Does the patient have Synovitis-acne-pustulosis-hyperostosis-osteitis (SAPHO) syndrome, primary erythrodermic psoriasis vulgaris, primary plaque psoriasis or drug-triggered acute generalized exanthematous pustulosis (AGEP) ? _____ If Yes, please circle all.

PLEASE NOTE:

- Please include a copy of RX to this document when transmitting to ARBDA/IDYLLIC. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required.
  - ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
  - *OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS*
  - *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*

- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- **!! IMPORTANT !!** *Please notify our office if the medication is discontinued.*

Ordering Provider Signature: _____