

Spevigo Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F. (609)228-9798 Attn: Idyllic Infusion Coordinator

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

Continuation of Care (Provide documentation of last administration)

New Start

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	
<p><i>We will gladly remind your patient to schedule routine follow-up visits with your office.</i></p> <p>Return to Referring Provider (frequency): EVERY _____ WKS / MOS</p>	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: Weight in lbs:	
Insurance(s)	Please include copies of front and back
Preferred Treatment Location	<input type="checkbox"/> Voorhees <input type="checkbox"/> Moorestown <input type="checkbox"/> Wall/Manasquan <input type="checkbox"/> Sewell <input type="checkbox"/> Hamilton <input type="checkbox"/> Galloway

Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:
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The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

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.*

□ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature: _____