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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <div style="display: flex; align-items: center;"> <div> <p><b>Oregon Health &amp; Science University<br/>Hospital and Clinics Provider's Orders</b></p> </div> </div> <div style="margin-top: 10px;"> <p>PO7071</p> </div> <div style="text-align: center; margin-top: 10px;"> <p>ADULT AMBULATORY INFUSION ORDER</p> <p><b>Spesolimab-sbzo (SPEVIGO)</b></p> <p><b>Infusion</b></p> </div> <div style="text-align: center; margin-top: 10px;"> <p>Page 1 of 3</p> </div> | <div style="margin-top: 10px;"> <p>ACCOUNT NO.</p> <p>MED. REC. NO.</p> <p>NAME</p> <p>BIRTHDATE</p> </div> <div style="text-align: right; margin-top: 20px;"> <p><i>Patient Identification</i></p> </div> |
| <p><b>ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.</b></p>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                            |

Weight: \_\_\_\_\_ kg      Height: \_\_\_\_\_ cm

Allergies: \_\_\_\_\_

Diagnosis Code: \_\_\_\_\_

Treatment Start Date: \_\_\_\_\_      Patient to follow up with provider on date: \_\_\_\_\_

**\*\*This plan will expire after 365 days at which time a new order will need to be placed\*\***

#### **GUIDELINES FOR ORDERING**

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Avoid spesolimab use in patients with active infection until it resolves or is adequately treated. Spesolimab may increase the risk of bacterial or viral infections, especially in patients with a history of recurrent or chronic infections.
3. Avoid use in patients with active tuberculosis infection. Consider pretreatment with antituberculosis therapy in patients with latent TB. Monitor patients for signs and symptoms of active TB during and after spesolimab treatment.
4. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.

#### **LABS**

- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

#### **NURSING ORDERS:**

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes

#### **MEDICATIONS**

- ☒ spesolimab-sbzo (SPEVIGO) 900 mg in sodium chloride 0.9% 100 mL total volume, intravenous, ONCE over 90 minutes



**Oregon Health & Science University  
Hospital and Clinics Provider's Orders**

**ADULT AMBULATORY INFUSION ORDER  
Spesolimab-sbzo (SPEVIGO)  
Infusion**

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ACCOUNT NO.  
MED. REC. NO.  
NAME  
BIRTHDATE

*Patient Identification*

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**HYPERSENSITIVITY MEDICATIONS:**

1. NURSING COMMUNICATION – If an infusion related reaction occurs, stop the infusion immediately. For mild to moderate reactions, once symptoms resolve may resume infusion at a slower rate and gradually increase to complete the infusion; the total infusion time (including stop time) should not exceed 180 minutes.
2. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
3. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
6. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction



Oregon Health & Science University  
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ADULT AMBULATORY INFUSION ORDER  
**Spesolimab-sbzo (SPEVIGO)  
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Patient Identification

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.**

**By signing below, I represent the following:**

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ \_\_\_\_\_ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

**My physician license Number is # \_\_\_\_\_ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION);** and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

**Provider signature:** \_\_\_\_\_ **Date/Time:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

***Please check the appropriate box for the patient's preferred clinic location:***

☐ **Beaverton**

OHSU Knight Cancer Institute  
15700 SW Greystone Court  
Beaverton, OR 97006  
Phone number: 971-262-9000  
Fax number: 503-346-8058

☐ **NW Portland**

Legacy Good Samaritan campus  
Medical Office Building 3, Suite 150  
1130 NW 22nd Ave  
Portland, OR 97210  
Phone number: 971-262-9600  
Fax number: 503-346-8058

☐ **Gresham**

Legacy Mount Hood campus  
Medical Office Building 3, Suite 140  
24988 SE Stark  
Gresham, OR 97030  
Phone number: 971-262-9500  
Fax number: 503-346-8058

☐ **Tualatin**

Legacy Meridian Park campus  
Medical Office Building 2, Suite 140  
19260 SW 65th Ave  
Tualatin, OR 97062  
Phone number: 971-262-9700  
Fax number: 503-346-8058

Infusion orders located at: [www.ohsuknight.com/infusionorders](http://www.ohsuknight.com/infusionorders)