COSENTYX IV
(secukinumab)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Medication List
- Most Recent Labs
- Tried/Failed Therapies
- Negative TB Results

PRIMARY DIAGNOSIS

☐ L40.50 Arthropathic psoriasis, unspecified

☐ L40.59 Other psoriatic arthropathy

☐ M45.0 Ankylosing spondylitis of multiple sites in spine

☐ M45.9 Ankylosing spondylitis of unspecified sites in spine

☐ M45.A0 Non-radiographic axial spondyloarthritis of unspecified sites in spine

☐ M45.AB Non-radiographic axial spondyloarthritis of multiple sites in spine

☐ Other: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Cosentyx

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ **With a loading dose:**
Cosentyx 6mg/kg IV (_____mg) at week 0, followed by 1.75mg/kg IV (_____mg) every 4 weeks thereafter (max maintenance dose 300mg per infusion).

Without a loading dose:
Cosentyx 1.75mg/kg IV (_____ mg) every 4 weeks thereafter (max maintenance dose 300mg per infusion).

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date