



COSENTYX IV (secukinumab)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
 6. Tried/Failed Therapies 7. Negative TB Results

PRIMARY DIAGNOSIS

<input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> L40.59 Other psoriatic arthropathy	<input type="checkbox"/> M45.0 Ankylosing spondylitis of multiple sites in spine <input type="checkbox"/> M45.9 Ankylosing spondylitis of unspecified sites in spine	<input type="checkbox"/> M45.A0 Non-radiographic axial spondyloarthritis of unspecified sites in spine <input type="checkbox"/> M45.AB Non-radiographic axial spondyloarthritis of multiple sites in spine <input type="checkbox"/> Other: _____
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LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

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).
 Other: _____

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

FIRST DOSE?: Yes No Refill x12 months unless otherwise noted. _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other Flush Orders: Please send other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X _____ DATE _____
 PROVIDER SIGNATURE