immersiv HEALTH

COSENTYX® IV ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- ☐ L40.5 Psoriatic Arthritis (PsA)
- ☐ M45.0 Ankylosing Spondylitis (AS)
- ☐ M45.A Non-Radiographic Axial Spondyloarthritis (nr-axSpaA)
- ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most Recent History & Physical ☐ Negative TB screening

MEDICATION ORDER

☐ **LOADING:** Cosentyx® (secukinumab) 6mg/kg IV in 100ml NS over 30 minutes at week 0

☐ **MAINTENANCE:** Cosentyx® (secukinumab) 1.75mg/kg IV over 30 minutes every 4 weeks

>52kg: infuse in 100ml NS

< or equal to 52kg: infuse in 50ml NS

*Maximum maintenance dose of 300mg

☐ **OTHER:** _____

*Flush with 20ml NS after each infusion

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

PRE-MEDICATIONS

PO

- ☐ Acetaminophen: 650 mg
- ☐ Cetirizine: 10 mg
- ☐ Diphenhydramine: 25 mg

IV

- ☐ Methylprednisolone: 125 mg
- ☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: (IF APPLICABLE) _____ **CONTACT NAME:** _____

SIGNATURE: (NO STAMPS) _____ _____ **DATE:** _____

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN