

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. Administer per protocol.
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: _____ CONTACT NAME: _____
(IF APPLICABLE)

SIGNATURE: _____ DATE: _____
(NO STAMPS)

SUBSTITUTION PERMITTED

DISPENSE AS WRITTEN