

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____
 Address: _____ City/ST/Zip: _____
 Allergies: _____ NKDA Weight: _____ lbs kg Height: _____ in cm
Patient Status: New to Therapy Dose or Frequency Change Order Renewal

INSURANCE INFORMATION: Please attach copy of insurance card (front and back).

DIAGNOSIS*

***ICD 10 Code
Required**

Ankylosing Spondylitis (M45.0-M45.9), ICD10 _____
 Arthropathic Psoriasis (L40.50-L40.59), ICD10 _____
 Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Cosentyx® (secukinumab)	<input type="checkbox"/> Loading Dose: _____ mg (6 mg/kg) <input type="checkbox"/> Maintenance Doses: _____ mg (1.75 mg/kg; MAXIMUM = 300 mg)	<input type="checkbox"/> Loading: Infuse IV over 30 minutes x 1 dose <input type="checkbox"/> Maintenance: Infuse IV over 30 minutes every 4 weeks x 1 year

Is patient currently receiving therapy above from another facility?
 Yes No
 If yes, Facility Name: _____
 Date of last treatment: _____ Date of next treatment: _____

PRE-MEDICATION ORDERS

No premeds ordered at this time
 Acetaminophen 650mg PO Diphenhydramine 25mg PO
 Methylprednisolone 40mg IVP -OR- Hydrocortisone 100mg IVP
 Other: _____

LAB ORDERS

Labs to be drawn by: Infusion Center Referring Physician
 No labs ordered at this time
 CBC q _____ CMP q _____ CRP q _____
 ESR q _____ LFTs q _____ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____
 Physician Name: _____ Provider NPI: _____ Specialty: _____
 Address: _____ City/ST/Zip: _____
 Contact Person: _____ Phone #: _____ Fax #: _____
 Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
 - Annual TB screening to be done by: Infusion Center Referring Physician

PRIOR FAILED THERAPIES

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
 Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____
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