Cosentyx IV
(secukinumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Arthropathic psoriasis, unspecified (L40.50)
☐ Other psoriatic arthropathy (L40.59)
☐ Ankylosing spondylitis of multiple sites in spine (M45.0)
☐ Ankylosing spondylitis of unspecified sites in spine (M45.9)
☐ Non-radiographic axial spondyloarthritis of unspecified sites in spine (M45.A0)
☐ Non-radiographic axial spondyloarthritis of multiple sites in spine (M45.AB)
☐ Other: _____

PRESCRIPTION

Cosentyx IV (secukinumab)

☐ Cosentyx 6mg/kg IV at week 0, followed by 1.75mg/kg IV every 4 weeks thereafter
☐ Cosentyx 1.75mg/kg IV every 4 weeks **max maintenance dose 300mg per infusion**
☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No
☑ Refill x 12 months unless otherwise noted: _____

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Tried/Failed Therapies
- Negative TB Results

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended standard pre-meds for Cosentyx IV
☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.