

Costentyx IV (Secukinumab IV)

REFERRAL STATUS: New Referral Dose or Frequency Change Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION

Date:	Patient Name:	DOB:
<input type="checkbox"/> NKDA Allergies:	Weight (lbs / kg):	Height:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy - Last Treatment Date:	Next Due Date:	

PROVIDER INFORMATION

Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: L40.50
<input type="checkbox"/> Ankylosing Spondylitis	ICD 10 Code: M45.0
<input type="checkbox"/> Non-Radiographic Axial Spondyloarthritis	ICD 10 Code: M45.A0
<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION/Testing

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary dx
<input type="checkbox"/> Patient demographics AND insurance info	<input type="checkbox"/> TB result

List Tried & Failed Therapies 1) _____ 2) _____

PREMEDICATION ORDERS

<input type="checkbox"/> acetaminophen (Tylenol) PO <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> diphenhydramine (Benadryl) PO / IV <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg (if route is not circled PO will be administered)
<input type="checkbox"/> methylprednisolone (Solu-Medrol) IV <input type="checkbox"/> 60mg <input type="checkbox"/> 100mg <input type="checkbox"/> 125mg <input type="checkbox"/> _____ mg
<input type="checkbox"/> Other:

MEDICATION ORDERS

Loading dosing	<input type="checkbox"/> 6 mg/kg IV once then 1.75 mg/kg IV (max dose 300 mg) every 4 weeks thereafter
Maintenance dosing	<input type="checkbox"/> 1.75 mg/kg IV every 4 weeks (max dose 300 mg)

Refills*: None X6 months X1 year Other: _____
**(if not indicated order will expire one year from date signed)*

SPECIAL INSTRUCTIONS

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Provider Name (Print) _____ Physician Signature: _____ Date: _____

Fax referral to 866-507-1164 or email to bionurses@metroinfusioncenter.com

All information contained in this order form is strictly confidential and will become part of the patient's medical record.