Cosentyx IV (Secukinumab IV)

MIC | METRO INFUSION CENTER

REFERRAL STATUS: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: _____

PATIENT INFORMATION			
Date:	Patient Name:		DOB:
☐ NKDA Allergies:		Weight (lbs / kg):	Height:
Patient Status: ☐ New to Therapy ☐ 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	
☐ Psoriatic Arthritis	ICD 10 Code: L40.50
☐ Ankylosing Spondylitis	ICD 10 Code: M45.0
☐ Non-Radiographic Axial Spondyloarthritis	ICD 10 Code: M45.A0
☐ Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION/Testing	
☐ This signed order form by the provider	☐ Clinical/Progress notes supporting primary dx
☐ Patient demographics AND insurance info	☐ TB result
List Tried & Failed Therapies 1)	2)

PREMEDICATION ORDERS

☐ acetaminophen (Tylenol) PO ☐ 500mg ☐ 650mg ☐ 1000mg

☐ diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)

☐ methylprednisolone (Solu-Medrol) IV ☐ 60mg ☐100mg ☐ 125mg ☐ _____ mg

☐ Other:

MEDICATION ORDERS	
Loading dosing	☐ 6 mg/kg IV once then 1.75 mg/kg IV (max dose 300 mg) every 4 weeks thereafter
Maintenance dosing	☐ 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

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.

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