RESTORE HEALTH
INFUSION AND WELLNESS

COSENTYX

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Name: _____ **DOB:** _____ **Gender:** ☐ M ☐ F ☐ Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER

Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL

Diagnosis: ☐ L40.0 (Psoriasis Vulgaris) ☐ M45.0 (Ankylosing Spondylitis) ☐ Other: _____

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

TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT

COSENTYX (Secukinumab)

Route: Intravenous Infusion

Dose: ☐ 1.75mg/kg ☐ 6mg/kg

Frequency:

- ☐ Loading Dose: 6mg/kg at week 0
- ☐ Maintenance Dose: 1.75mg/kg every 4 weeks

Maintenance doses over 300mg per infusion are not recommended

Premedication Protocol: *(Not Usually Indicated)*

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

■ *Center will use anaphylactic and hypersensitivity protocol established by Restore Health*

Special Instructions: _____

_____

_____

_____

Provider Signature: _____ Date: _____