

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: _____

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