RESTORE HEALTH
INFUSION AND WELLNESS

COSENTYX

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

PATIENT INFORMATION

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

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

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

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

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

Phone: _____ Fax: _____

CLINICAL INFORMATION

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 INFORMATION

COSENTYX (Secukinumab)

Route: Intravenous Infusion

Dose: ☐ 1.75mg/kg ☐ 6mg/kg

Frequency:

☐ Loading Dose: 6mg/kg at week 0

☐ Maintenance: 1.75mg/kg every 4 weeks

Maintenance doses over 300mg per infusion are not recommended

Premedication Protocol: *(Not Usually Recommended)*

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

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

☐ Other: _____

Sig: _____

Special Instructions: _____

Quantity: _____ Refills: _____

Provider Name: _____ Provider Signature: _____ Date: _____