COSENTYX INFUSION ORDER (SECUKINUMAB)

Date: ____/____/_____

PATIENT INFORMATION

Patient Name:_____ DOB:___/____/____ Phone: _____

Height: _____ Weight(Required):_____ lbs/kg

Allergies: _____

MEDICAL INFORMATION

ICD-10 & Diagnosis:

- ☐ L40.00: Plaque Psoriasis (PsO)
- ☐ L40.50: Psoriatic Arthritis (PsA)
- ☐ M45: Ankylosing Spondylitis (AS)
- ☐ M45.A0: Non-Radiographic Axial Sondyloarthritis (nr-axSpA)
- ☐ M76: Enthesitis-related Arthritis (ERA)
- ☐ Z79.620: Long term (Current) use of immunosuppressive biologic.
- ☐ Other: _____

COSENTYX THERAPY ORDER

- ☐ Cosentyx 6mg/kg Week 1
- ☐ Cosentyx 1.75mg/kg every 4 weeks x 1 year (Should not Exceed 300mg)

Start Date of Infusion: ___/___/___ End Date: ___/___/___

PROVIDER INFORMATION

Provider's Name: _____

Provider's NPI: _____ Signature: _____

Phone: _____ Fax: _____ Date: _____/_____/_____

Office Address: _____

Email Address: _____ Contact Person: _____

PLEASE FAX COMPLETED FORM, CLINICAL DOCUMENTATION, DEMOGRAPHICS & COPY OF INSURANCE CARD

PHONE: 972-810-0990 | FAX: 972-810-0994