INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Cosentyx *secukinumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Psoriatic Arthritis, ICD 10: L40.5
☐ Ankylosing Spondylitis, ICD 10: M45.9
☐ Non-radiographic Axial Spondyloarthritis, ICD 10: M45.A
☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB test
☐ Office/progress notes
☐ Demographics
☐ Labs and tests supporting diagnosis

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO
☐ Diphenhydramine (Benadryl) 25 mg PO
☐ Famotidine 20 mg IV
☐ Cetirizine (Zyrtec) 10 mg PO
☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	DOSE	ROUTE	FREQUENCY
Cosentyx	☐ With loading dose: 6 mg/kg at week 0, followed by 1.75 mg/kg every 4 weeks thereafter ☐ Without loading dose: 1.75 mg/kg *Loading dose optional *Max. maintenance dose 300 mg per infusion	IV	Every 4 weeks

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____