EXPECARE FAMILY CARE URGENT CARE OF TEXAS

Cosentyx IV Order Form
(secukinumab)

FAX TO: 817-472-7213

PATIENT INFORMATION

Patient Name: _____

DOB: _____ Phone: _____ Sex: ☐ M ☐ F

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (Required)

- ☐ L40.50 Arthopathic psoriasis, unspecified
- ☐ M45.9 Ankylosing Spondylitis, unspecified site of spine
- ☐ M45.A0 Non-radiographic axial spondyloarthritis of unspecified sites of spine
- ☐ Other: _____

Weight: _____ ☐ lb ☐ kg Height: _____

Patient Status:

- ☐ New to therapy
- ☐ Continuing therapy (date of last dose (817) 472-7601)

Allergies: _____

PRESCRIPTION

COSENTYX (secukinumab)

- ☐ **IV Loading Dose:** Infuse 6 mg/kg at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter for one year
- ☐ **IV Maintenance Dose:** 1.75 mg/kg every 4 weeks for one year

Is the patient on any other disease modifying therapy? ☐ **Yes** ☐ **No**

Is yes, please note therapy and last dose: _____

Adverse Events: In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reactions protocol

Other Orders:

_____

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING AND INSURANCE APPROVAL

- Signed and completed order
- Patient's demographic and insurance information
- Patient's medication list
- Supporting clinical notes that include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Supporting labs/diagnostics:
Negative TB within 12 months of initiating therapy

Medix Infusion will collect all necessary labs if not included in referral documents

PRESCRIBER INFORMATION

Prescriber Name: _____

Signature: _____

NPI #: _____ Date: _____

Supervising Physician (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____