medix infusion

Cosentyx® IV Order Form
(secukinumab)

FAX TO: 972.499.9210

Patient Information

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F

Ht: _____ Wt: _____☐ lbs ☐ kg Primary Language: _____

Allergies: _____Patient Preferred Location: _____

Diagnosis

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 ICD 10 Code: _____
  Description _____

Patient Status

- ☐ New to therapy
- ☐ Continuing therapy (date of last dose _____)

Maximum Dose Parameters, if applicable _____

Infusion Orders

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

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

Comments:

_____

_____

Lab Orders+
Requested Add'l Lab Orders:

_____

_____

Lab Frequency: _____every _____weeks

Required Clinical Documentation

- 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

Medix Infusion will collect all labs if not included within referral documents.

Supporting Labs/Diagnostics
Negative TB within 12 months of initiating therapy

Is the patient on any other disease modifying therapy?
☐ Yes ☐ No
If yes, please note therapy and last dose:

_____

Referring Provider Information

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

Contact Name: _____ Phone: _____ Fax: _____ Email: _____