Cosentyx® IV Order Form
(secukinumab)

medix infusion

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 + Maintenance 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

Lab Orders
Requested Add'l Lab Orders:
_____
_____

Lab Frequency: _____every _____weeks

Comments: _____

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**

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

LAB RESULTS:
Negative TB within 12 months of initiating therapy

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

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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