COSENTYX IV
(secukinumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results

PRIMARY DIAGNOSIS

☐ L40.50 Arthropathic psoriasis, unspecified
☐ L40.59 Other psoriatic arthropathy
☐ M45.0 Ankylosing spondylitis of multiple sites in spine
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine
☐ M45.A0 Non-radiographic axial spondyloarthritis of unspecified sites in spine
☐ M45.AB Non-radiographic axial spondyloarthritis of multiple sites in spine
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Cosentyx
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ **With a loading dose:**
Cosentyx 6mg/kg IV (_____mg) at Week 0, followed by 1.75mg/kg IV (_____mg) every 4 weeks thereafter (max maintenance dose 300mg per infusion).

☐ **Without a loading dose:**
Cosentyx 1.75mg/kg IV (_____mg) every 4 weeks thereafter (max maintenance dose 300mg per infusion).

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals