

Cosentyx IV (secukinumab)

Provider Order Form rev. 1/2/2025



PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ L40.50 Arthropathic psoriasis, unspecified

☐ Other: _____

☐ M45.9 Ankylosing Spondylitis, unspecified site of spine

☐ M45.A0 Non-radiographic axial spondyloarthritis of unspecified sites of spine

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel depending on medication), signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO

☐ Cetirizine (Zyrtec) 10mgPO

☐ Loratadine (Claritin) 10mgPO

☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Negative TB within 12 months of initiating therapy

☐ Other: _____

COSENTYX (secukinumab) IV (Select one):

Loading Dose:

☐ Infuse 6 mg/kg at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter for one year

Maintenance Dose:

☐ Infuse 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: _____

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

Special Instructions: _____

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

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

Provider Name (Print)

Provider Signature

Date

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454