

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
 M45.9 Ankylosing Spondylitis, unspecified site of spine
 M45.A0 Non-readiographic axial spondyloarthritis of unspecified sites of spine

Other: _____

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