



Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to: FAX: 410-220-2553

COSENTYX ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Fax:	Direct Phone for Contact:	
Patient Name:	DOB:	

Allergies NKDA Allergies: _____

_____ Height: _____

_____ Weight: _____

Indication:

L40.5 ___ PsA

M45. ___ AS

M45.A ___ nr-axPsA

Other _____

DOSAGE ORDERS:

6mg/kg X 1 then 1.75mg/kg every 4 weeks

1.75mg/kg every 4 weeks

PREMEDICATION ORDERS: *not required by PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name: Title: _____

NPI:	DEA:
Prescriber Signature: Date of Order:	

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____