CURBSIDE
INFUSION SERVICES

COSENTYX (SECUKINUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: ______________________________ DOB: __________

Mobile Number: ______________________ Patient Weight: ______________________

Allergies: ____

DIAGNOSIS (Provider must specify)

❑ Psoriatic Arthritis, ICD 10: L40.5

❑ Ankylosing Spondylitis, ICD 10: M45.9

❑ Non-radiographic Axial Spondyloarthritis, ICD 10: M45.A

❑ Other: ______________________

PROVIDER INFORMATION

Provider Name (print name): ______________________ Provider NPI: __________

Signature: ______________________________ Date: __________

Contact Name: ______________________ Phone: __________ Fax: __________

Email Address: ____

Prerequisites to treatment – ensure the following information is complete and attached with referral:

❑ Demographics ❑ Labs and tests supporting diagnosis ❑ Office/progress notes

PRE-MEDICATION (Not typically indicated)

❑ Acetaminophen (Tylenol) 500 mg PO

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Quzyttir 10mg IVSP over 1-2 min

❑ Other: ______________________ Dose: __________ Route: __________

MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Cosentyx	❑ 1.75mg/kg (Max maintenance dose is 300mg q4wk) ****Optional loading dose of 6mg/kg given on week/ day 0** ❑ Other: _______	❑ IV	❑ q4wks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): ______________

FAX NUMBERS: ❑ NH: 603.217.5371 ❑ ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: ____________