Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Cosentyx Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Psoriatic Arthritis (PsA)
  ICD-10:_____
- ☐ Ankylosing Spondylitis (AS)
  ICD-10:_____
- ☐ Non-radiographic axial spondyloarthritis (nr-axSpA)
  ICD-10:_____
- ☐ Other_____ICD-10:_____

ORDER FOR COSENTYZ (SECUKINUMAB):

- ☐ 6mg/kg IV at Week 0, followed by 1.75mg/kg IV every 4 weeks thereafter x 1 year
- ☐ 1.75mg/kg IV every 4 weeks x 1 year
- ☐ **Other:** _____ x 1 year.
  Max maintenance dose (1.75mg/kg) is 300mg

PRE-MEDICATIONS:

- ☑ Acetaminophen 650mg PO
- ☑ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☑ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☑ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)

☐ Patient demographic and insurance information

☐ Patient's current medication list

☐ Supporting recent clinical notes and H&P (to support primary diagnosis)

☐ Supporting documentation to include past tried and/or failed therapies

☐Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?

☐Yes OR ☐ No

If yes, which drug(s)? _____

☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?

☐ Yes OR ☐ No

If yes, which drug(s)? _____

☐ Include labs and/or test results to support diagnosis - please include results

☐ CRP and/or ESR

☐ Other applicable diagnostic testing and/or labs

☐ If applicable - Last known biological therapy: _____ and last date received: _____
** If the patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Cosentyx.

☐ Other medical necessity documentation (please include): _____

Additional REQUIRED Information:

☐ TB screening test completed within 12 months - please include results

☐ Positive OR ☐ Negative

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

Revised 04/25