COSYNTYX® Infusion Form

Fax Referral To: 877-438-9380

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: ____________________ Next Infusion Date: ____________________

Patient Information

Patient Name:____________________________ DOB: ________________ Sex: M F Height: ______ Weight: ________________

Phone Number: ______________________________ Email Address: ____

Allergies: ____ Is the patient Diabetic: Y N ICD-10 Code: ____________________

Emergency Contact:____ Phone Number: ____

Primary Diagnosis:

________ Plaque psoriasis
________ Ankylosing spondylitis
________ Arthropathic psoriasis, unspecified
________ Other psoriatic arthropathy
________ Other: ____

Does this patient have documented efficacy failure of adequate trial on Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment? Yes ______________________ No If YES, please indicate which drug(s) and date(s) of usage. Enbrel® Date: _______ Remicade® Date: _______ Cimzia® _______ Taltz® Date: _______ Humira® Date: _______ Stelara® Date: _______ Simponi® Date: _______ Other ______________________ Date: _______ Has patient participated in a COSENTYX clinical trial? YES NO The patient has previously been treated with a biologic for the diagnosed condition. YES NO If patient has been treated with a biologic, please answer the following questions. Does this patient have a contraindication, intolerance, or allergy to Enbrel®, Humira®, Remicade®, Stelara®, Cimzia®, Simponi®, Taltz®, or other biologic treatment? Yes ______________________ No

Please attach the following: 1. List of current Medications 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening:________________

Physician Information

Prescribing Physician: ______________________________ Practice Name: ______________________________
Practice Phone: ______________________________ Practice Fax: ______________________________
Email: ______________________________ Office Contact: ______________________________
Co-managing Physician: ______________________________ Phone/Email: ______________________________

Medication Order

Medication: **COSENTYX® (SECUKINUMAB)**

Cosentyx: 300 mg or 150mg

New Start:

SENSOREADY® PEN	Prefilled Syringe
Inject 300 mg dose subcutaneiously (2 injections of 150 mg)	Inject 150 mg dose subcutaneiously

Initial weekly loading dose? (Weeks 0, 1, 2, 3, 4) Yes No

\# of Monthly Refills (Once every 4 weeks) ______________________________

Pre-Medication Orders: *No pre-medications are recommended based on manufacturer guidelines.*

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

______________________ ______________________________
Physician's NPI# Physician's Address

______________________________ ______________________
Prescriber's Signature Date

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