REVITALIZE
INFUSION CENTER

Cosentyx®

Infusion Order Form

Patient Information:

_____ _____ _____

Patient Name **DOB** **Phone Number**

Medical Information:

Primary Diagnosis:

☐ Ankylosing Spondylitis (AS) of _____ region ICD-10 Code: M45.0
☐ Psoriatic Arthritis (PsA) ICD-10 Code: L40.5
☐ Non-radiographic axial spondyloarthritis of _____ ICD-10 Code: M45.A
☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Medication List
  - Include previously tried and failed therapies
- Relevant labs and tests
- Required Information:
  - TB screening results

Height: _____

Weight: _____

Cosentyx (secukinumab) Orders:

☐ Loading Dose: Administer 6 mg/kg IV (_____ mg) at week 0
☐ Maintenance Regimen: Administer 1.75 mg/kg IV (_____ mg) every 4 weeks (max dose of 300 mg) approximately four (4) weeks following the administration of the loading dose or the last infusion for 12 months.

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO ☐ Cetirizine 10 mg PO ☐ Diphenhydramine 50 mg IV
☐ Loratadine 10 mg PO ☐ Other: _____

Lab Orders: _____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____ _____

Prescriber's Signature **Date**

_____ _____

Prescriber's Printed Name **Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize Revitalize Locations InfusionPlus