hŏúi2oŜ№ нлнп

Ascend
INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

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 <u>ALL</u> 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: _____