



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
 M45.9 ___ AS
 M45.A ___ nr-axPSA
 Other _____

DOSAGE ORDERS:

With loading dose: 6mg/kg IV X 1 then 1.75mg/kg IV every 4 weeks *Loading dose optional
 Without loading dose: 1.75mg/kg IV every 4 weeks *Max maintenance dose 300mg per infusion

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.
 Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.
 Methylprednisolone: 62.5mg IVP 125mg 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 ALL 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: _____