COSENTYX® Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	F: 703-935-2061

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
_____ Arthropathic psoriasis, unspecified
_____ Other: _____
_____ Ankylosing spondylitis
_____ Other psoriatic arthropathy

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 ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date