Secukinumab IV (Cosentyx IV)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ L40.50 Arthropathic psoriasis, unspecified	☐ L40.59 Other psoriatic arthropathy
☐ M45.0 Ankylosing spondylitis of multiple sites in spine	☐ M45.A0 Non-radiographic axial spondyloarthritis of unspecified sites in spine
☐ M45.9 Ankylosing spondylitis of unspecified sites in spine	☐ M45.AB Non-radiographic axial spondyloarthritis of multiple sites in spine
☐ Other:	

PRIMARY MEDICATION ORDER

Secukinumab IV (Cosentyx IV) Infused over 30 minutes
• Flush with 0.9% sodium chloride at infusion completion
• Refill for 12 months unless otherwise noted: _____

☐ ***Optional loading dose:*** 6mg/kg given at week 0, followed by 1.75mg/kg every 4 weeks thereafter. Max. maintenance dose 300mg per infusion

☐ ***Maintenance:*** 1.75mg/kg every 4 weeks. Max. maintenance dose 300mg per infusion

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Cosentyx

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV
☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV
☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐at each dose ☐every _____
☐ CMP ☐at each dose ☐every _____
☐ CRP ☐at each dose ☐every _____
☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772
☐ Arbor Infusion Carmel (317) 981-1772