

Secukinumab IV (Cosentyx IV)

Provider Order Form rev. 8/24/26



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)

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|---|--|
| ☐ 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
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☐ 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