INTRAMED Plus
infusion services

COSENTYX®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD-10 Code):

Primary Diagnosis:

_____ Ankylosing Spondylitis (AS) of _____ region ICD-10 Code: M45.0 ____

_____ Psoriatic Arthritis (PsA) ICD-10 Code: L40.5 _____

_____ Non-radiographic axial spondyloarthritis of _____ ICD-10 Code: M45.A ____

_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information — Please fax with Infusion Order Form:

Patient
Weight: _____ lbs.
Height _____ in.

- Clinical documentation supporting primary diagnosis
- Recent Lab/Test Results including:
  - o TB results
- Medication List
- Previous Drug Therapy History, including therapies trialed/failed and date of last administration:

  ❑ **Cimzia** ❑ **Enbrel** ❑ **Humira** ❑ **Infliximab** ❑ **Skyrizi** ❑ **Stelara** ❑ **Other:** _____

  o Date _____ Desired Washout Period: _____ week(s)
- Lab Orders: _____ **Frequency:** ❑ Every infusion ❑ Other: _____

COSENTYX® (secukinumab) J Code: J3247

4. Drug Order:

❑ **Loading Dose**

Administer 6 mg/kg IV (_____ mg) at week 0 Doses Authorized: 1 (one)

❑ **Maintenance Regimen ***

Administer 1.75 mg/kg IV (_____ mg) every 4 weeks Doses Authorized: 12 (twelve)

*Maintenance Regimen: To begin 4 weeks after start of loading dose & max dose of 300 mg per infusion as recommended in PI

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 this form and utilizing our services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____

Dispense as written Substitution permitted

Printed Physician's Name with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**