LivWell INFUSIONS

Cosentyx Infusion Order

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- L40.0 Plaque Psoriasis
- L40.5 Psoriatic Arthritis (PsA)
- L40.54 Psoriatic Juvenile Arthropathy
- L73.2 Hidradenitis Suppurativa
- M08.90 Juvenile Arthritis, unspecified
- M45.0 Ankylosing Spondylitis
- M45.A Non-Radiographic Axial Spondyloarthritis

ICD-10 _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- Clinical/ Progress Notes
- Demographics Sheet
- Current Medications
- Labs

COSENTYX ORDER

Cosentyx Dose:

- 6mg/kg IV at Week 0, followed by 1.75mg/kg IV every 4 weeks thereafter x 1 year
- 1.75mg/kg IV every 4 weeks x 1 year

PreMeds:

- Benadryl 50mg IV
- APAP 500 mg PO
- Famotidine 20mg IV
- Benadryl 50 mg PO

Date of last Cosentyx Infusions: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____