Cosentyx® (secukinumab)

Horizon Infusions

**For new referrals, please include recent labs and last two office visit notes.**

## Fax completed form to (315) 457-4305

Phone (315) 457-3091

### 1. PATIENT INFORMATION

| | |
|---|---|
| **Name:** | **DOB:** |
| **Phone:** | **Other Phone:** |
| **Email:** | |
| **Social Security #:** | **Allergies:** |
| **Gender:** ☐ M ☐ F | **Weight:** ☐ Lbs ☐ Kg |

**Patient Status:** ☐ New to therapy ☐ Continuing therapy ☐ Next due date *(if applicable)*:

### 2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

### 3. PHYSICIAN INFORMATION

| | | |
|---|---|---|
| **Physician Name:** | | **NPI#:** |
| **License #:** | **TIN#:** | **DEA#:** |
| **Address:** | | |
| **City:** | | **State** **Zip** |
| **Office Contact:** | | **Email:** |
| **Office phone:** | | **Office fax:** |

### 4 . DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Non-Radiographic Axial Spondyloarthritis(_____)
☐ Ankylosing Spondylitis (_____)
☐ Psoriatic Arthritis (_____)
☐ Other: _____

***Labs: TB within last year required (prior to starting only)**

### 5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

☐ Loading: 6mg/kg IV week 0

☐ Maintenance: 1.75mg/kg IV Q4 weeks (MAX maintenance dose 300mg Q infusion)

☐ Vital signs per HI protocol

☐ Anaphylaxis & Hydration Management per HI protocol

**PRE-MEDICATIONS** ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other _____

**POST-MEDICATIONS** ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Prednisone _____ mg PO
☐ Other _____

### 6. LABS

| | | |
|---|---|---|
| ☐ CBC w/Diff | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ CRP | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ CMP | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ ESR | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ Hepatic Panel | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |
| ☐ Renal Panel | ☐ Each Infusion | ☐ Other Frequency (*specify*): _____ |

☐ Quantiferon TB Gold, annually, last completed *(date)*: _____
☐ Other (*specify*):_____

### 7. SIGNATURE (required)

**PHYSICIAN'S SIGNATURE** **DATE**