

Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Marlton
127 Church Road
Suite 600
Marlton, NJ 08053



Secukinumab IV (Cosentyx IV)

Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

LABORATORY ORDERS
<input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____
<input type="checkbox"/> Other: _____

PRE-MEDICATION ORDERS
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> cetirizine (Zyrtec) 10mg PO
<input type="checkbox"/> loratadine (Claritin) 10mg PO
<input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV
<input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV
<input type="checkbox"/> hydrocortisone (Solu-Cortef) <input type="checkbox"/> 100mg IV
<input type="checkbox"/> Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS
<div style="border: 1px solid black; height: 60px; width: 100%;"></div>

THERAPY ADMINISTRATION
<input checked="" type="checkbox"/> Secukinumab IV (Cosentyx IV) Please indicate if both loading dose and Maintenance doses are needed.
<input checked="" type="checkbox"/> Loading Dose <ul style="list-style-type: none">Dose: 6mg/kgFrequency: once at week 0Route: Intravenous <i>(Maintenance doses will be given every 4 weeks thereafter)</i>
<input type="checkbox"/> Maintenance Dose <ul style="list-style-type: none">Dose: 1.75mg/kg (maximum maintenance dose 300mg per infusion)Frequency: Every 4 weeksRoute: Intravenous
<input checked="" type="checkbox"/> Infuse over 30 minutes
<input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at infusion completion
<input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)
Total dosages _____
Refills _____

NOTES/ADDITIONAL COMMENTS:
<div style="border: 1px solid black; height: 50px; width: 100%;"></div>

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____