☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ *NYC Central Park West*
115 Central Park West
Suite 15
New York, NY 10023

☐ *Woodbury*
75 Froehlich Farm
Woodbury, NY 11797

☐ *Staten Island*
27 New Dorp Lane
Staten Island, NY 10306

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Bronx*
226 West 238th Street
Bronx, NY 10463

Secukinumab IV (Cosentyx IV)

Provider Order Form

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

☑ **Secukinumab IV** (Cosentyx IV) Please indicate if both loading dose and Maintenance doses are needed.

☑ **Loading Dose**
- Dose: 6mg/kg
- Frequency: once at week 0
- Route: Intravenous

(Maintenance doses will be given every 4 weeks thereafter)

☐ **Maintenance Dose**
- Dose: 1.75mg/kg (maximum maintenance dose 300mg per infusion)
- Frequency: Every 4 weeks
- Route: Intravenous

☑ Infuse over 30 minutes
☑ Flush with 0.9% sodium chloride at infusion completion
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Total dosages _____
Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____