

# TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: [referral@12stonehealth.com](mailto:referral@12stonehealth.com)



## COSENTYX IV ORDER FORM

Patient Name: _____	ICD-10 Code: _____	<b>Therapy Status</b>	
Date of Birth: _____	Allergies: _____	<input type="checkbox"/> New Start	
Weight: _____ lbs OR _____ kg		<input type="checkbox"/> Continuing Therapy: Last Dose: _____	

## PROVIDER INFORMATION

Ordering Provider: _____	Provider Fax: _____
Provider NPI: _____	Provider Address: _____
Provider Phone: _____	

## MEDICATION ORDER

<b>Cosentyx IV</b>  **indicated only for Psoriatic Arthritis, Ankylosing Spondylitis and Non-Radiographic Axial Spondyloarthritis**	<input type="checkbox"/> Loading Dose and Maintenance Dosing: Administer Cosentyx 6mg/kg IV at Week 0, followed by Cosentyx 1.75mg/kg IV every four weeks thereafter.  <input type="checkbox"/> Maintenance Dose Only: Administer Cosentyx 1.75mg/kg IV every four weeks.  <input checked="" type="checkbox"/> Total doses exceeding 300mg per infusion are not recommended for the 1.75mg/kg maintenance dose.	Refills for one year from date of signature unless indicated below.  _____ Refills	<i>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</i>  <input checked="" type="checkbox"/> Negative TB result and date: _____
-------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

## PRE-MEDICATIONS

<b>Oral</b>	<b>IV</b>
<input type="checkbox"/> Acetaminophen: 325mg _____ 500mg _____ 650mg <input type="checkbox"/> Loratadine: 10mg <input type="checkbox"/> Cetirizine: 10mg <input type="checkbox"/> Diphenhydramine: 25mg _____ 50mg <input type="checkbox"/> Famotidine: 20mg _____ 40mg <input type="checkbox"/> Ibuprofen: 200mg _____ 400mg _____ 600mg <input type="checkbox"/> Ondansetron: 4mg _____ 8mg <input type="checkbox"/> Other: _____	<input type="checkbox"/> Dexamethasone: 4mg _____ 8mg <input type="checkbox"/> Diphenhydramine: 25mg _____ 50mg <input type="checkbox"/> Famotidine: 20mg _____ 40mg <input type="checkbox"/> Methylprednisolone: 125mg <input type="checkbox"/> Hydrocortisone: 100mg <input type="checkbox"/> Ondansetron: 4mg _____ 8mg <input type="checkbox"/> Other: _____

<b>LAB ORDERS</b> (please indicate any labs to be drawn and frequency)	<b>OTHER REQUIRED DOCUMENTATION</b>
	(Please fax this signed order form, along with the following documents to 800-223-4063) <ul style="list-style-type: none"> <li>• History &amp; Physical, Last Office Visit Note</li> <li>• Patient Demographics and Insurance Information</li> <li>• Medication List</li> <li>• Recent Lab Work</li> </ul>

\*\*Surveillance lab ordering and monitoring is the responsibility of the prescriber\*\*

**By signing below, I certify that the above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

*By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.*

Prescriber Signature

Date