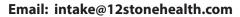
TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





COSENTYX IV ORDER FORM					
Date:	ICD-10 Code:	ICD-10 Code:		Therapy Status	
Patient Name:	Allergies:	Allergies:			
Date of Birth:	Weight:Ibs OR	kg	☐ Continuing Thera	apy: Dose:	
PROVIDER INFORMATION					
Ordering Provider:					
Provider NPI:		Provider Address:			
Provider Phone:					
MEDICATION ORDER					
Cosentyx IV **indicated only for Psoriatic Arthritis, Ankylosing Spondylitis and Non-Radiographic Axial Spondyloarthritis** □ Loading Dose and Maintenance Dosing: Administer Cosentyx 1.75mg/kg IV every weeks thereafter. □ Maintenance Dose Only: Administer Cosentyx 1.75mg/kg IV every weeks. ✓ Total doses exceeding 300mg per infusion not recommended for the 1.75mg/kg maintenance dose.		four Ref	fills for one year from te of signature unless indicated below. Refills	Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion: V Negative TB result and date:	
PRE-MEDICATIONS					
Oral		IV			
□ Acetaminophen:	325mg500mg650mg		methasone:4mg	· ·	
□ Loratadine: 10mg		☐ Diphenhydramine:25mg50mg			
□ Cetirizine: 10mg		□ Famotidine:20mg40mg			
□ Diphenhydramine:25mg50mg		☐ Methylprednisolone: 125mg			
Famotidine:20mg40mg		☐ Hydrocortisone: 100mg ☐ Ondansetron:4mg8mg			
☐ Ibuprofen: 200mg 400mg 600mg		Other:			
☐ Ondansetron:4mg8mg ☐ Other:					
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTHER REQUIRED DOCUMENTATION		
(place make any labe to be drawn and nequelley)		(Please fax this signed order form, along with the following documents to 800-223-4063) • History & Physical, Last Office Visit Note • Patient Demographics and Insurance Information • Medication List			
Surveillance lab ordering and monitoring is the responsibility of the prescriber			Recent Lab Work		
By signing this form, I am authorize	ing below, I certify that the above therapy is med ting TwelveStone Health Partners and affiliates to serve as m n respect to this patient and prescription order. This enrollme	ny designated ag	gent in submitting prior authoriza	ations and other clinically required information	
Dispense as Written:			Substitution Allowed:		
Prescriber Signature	 	Prescriber	Signature	 	
	2410		J. 3.101010	Date	