TwelveStone Health Partners
Fax Referral To: (615) 278-3355
Direct Phone: (844) 893-0012
Email: referral@12stonehealth.com

COSENTYX IV ORDER FORM

Patient Name: _____ ICD-10 Code: _____

Date of Birth: _____ Allergies: _____

Weight: _____ lbs OR _____ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____

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 6mg/kg IV at Week 0, followed by Cosentyx 1.75mg/kg IV every four weeks thereafter.

☐ Maintenance Dose Only: Administer Cosentyx 1.75mg/kg IV every four weeks.

✓ 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

Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:

✓ Negative TB result and date: _____

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg
- ☐ Famotidine: ☐ 20mg ☐ 40mg
- ☐ Ibuprofen: ☐ 200mg ☐ 400mg ☐ 600mg
- ☐ Ondansetron: ☐ 4mg ☐ 8mg
- ☐ Other: _____

IV

- ☐ Dexamethasone: ☐ 4mg ☐ 8mg
- ☐ Diphenhydramine: ☐ 25mg ☐ 50mg
- ☐ Famotidine: ☐ 20mg ☐ 40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ☐ 4mg ☐ 8mg
- ☐ Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 615-278-3355)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

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

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