O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Cosentyx IV (Secukinumab IV)

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal
Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION		
Date: Patient Name:		DOB:
☐ NKDA Allergies:		Weight (kg):
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE		REQUIRED DOCUMENTATION
☐ Psoriatic Arthritis	ICD 10 Code: L40.50	☐ This signed order form by the provider
☐ Ankylosing Spondylitis	ICD 10 Code: M45.0	☐ Patient demographics AND insurance information (copy of cards)
☐ Non-Radiographic Axial Spondyloarthritis	ICD 10 Code: M45.A0	☐ Clinical/Progress notes
☐ Other: _____	ICD 10 Code: _____	☐ Lab and Tests supporting primary diagnosis
		☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
		☐ Hepatitis C Test Results
		☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

PREMEDICATION ORDERS

☐ No premeds
☐ Acetaminophen (Tylenol) PO ☐ 500mg ☐ 1000mg
☐ Diphenhydramine (Benadryl) **PO / IV** ☐ 25mg ☐ 50mg (if route is not circled PO will be administered)
☐ Methylprednisolone (Solu-Medrol) IV ☐ 125mg ☐ 62.5mg
☐ Fexofenadine (Allegra) PO ☐ 180mg

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)

Loading Dosing	☐ 6mg/kg IV once then 1.75 mg/kg IV (max dose 300mg) every 4 weeks there after
Maintenance Dosing	☐ 1.75mg/kg IV every 4 weeks (max dose 300mg)
Refills	☐ None ☐ X6 months ☐ X1 year ☐ Other: _____

**Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.*

LAB ORDERS

☐ CBC w/ diff ☐ CMP ☐ CRP ☐ ESR ☐ Vitamin D OH Total ☐ Hep B Surface Antigen ☐ Quantiferon TB Gold ☐ Other:
☐ w/ every infusion ☐ w/ every other infusion ☐ Other:

_____

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

All information contained in this order form is strictly confidential and will become a part of the patient's medical record.