

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB Results**PATIENT INFORMATION**Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): L40. M45. ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____**PROVIDER INFORMATION**

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING Center will use Hypersensitivity protocol established by Infusion for Health and PI TB Results (list results & attached clinicals)
_____**LABORATORY ORDERS** CBC at each dose every _____ CMP at each dose every _____ Other: _____ Frequency: _____ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.**PRE-MEDICATION ORDERS**

Pre-medications not usually indicated.

 Diphenhydramine 25mg / 50mg PO / IV Acetaminophen 325mg / 500mg / 650mg PO Other: _____

Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:**THERAPY ADMINISTRATION** Cosentyx Intravenous Infusion Loading Dose: 6mg/kg at Week 0, then 1.75mg/kg every 4 weeks thereafter Maintenance Dose: 1.75mg/kg every 4 weeks
Maintenance doses exceeding 300 mg per infusion are not recommended. Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)*To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.*

_____	_____	_____
Provider Name (Print)	Provider Signature	Date

 Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.