

COSENTYX IV®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION			
Name: DOB:		Prescriber Name:			
Address:		State License:			
City, State, Zip:		NPI #: DEA:			
Phone: Alt. Phone:		Address:			
Email: SS#:		City, State, Zip:			
Gender: M F Weight:(lbs) Ht:		Phone: Fax:			
Allergies:		Office Contact: Phone:			
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)					
Primary Insurance:		Secondary Insurance (If Applicable):			
Plan #:		Plan #:			
Group #:		Group #:			
RX Card (PBM):		RX Card (PBM):			
BIN: PCN:		BIN: PCN:			
CLINICAL INFORMATION					
☐ L40.8 Psoriatic Arthritis ☐ M45.9 Anky	rlosing Spondylitis Other (spe	ecify ICD-10):			
Currently on therapy? ☐ Yes ☐ No Act	ive TB ruled out? □Yes □ No D	Date Active Hep B ruled out? Yes	□ No Date		
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities? - OR - ☐ Yes ☐ No Because patient is of childbearing age?					
ORDERS					
Prescription type: ☐ New start ☐ Restart ☐	Continued therapy Total Doses Re	ceived: Date of Last Injection/Infusion:			
Medication	I	ose/Frequency QTY/Refills			
Cosentyx® IV	☐ Loading Dose – 6 mg/kg		QTY:		
	☐ Frequency: Once at we	- 6			
	☐ Route: Intravenous		Refills:		
	(Maintenance dose will be given every 4 weeks thereafter)				
	☐ Maintenance Dose- 1.75 mg/kg (maximum maintenance dose 300				
	mg per infusion)				
	☐ Frequency: Every 4 weeks ☐ Route: Intravenous				
	☐ Infuse over 30 minutes				
	☐ Flush with 0.9% sodium chloride at infusion completion				
Pre-Medication	Dose/Strength	Directions			
☐ Acetaminophen	□ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-ir	nfusion as directed		
☐ Diphenhydramine ☐ 25mg		☐ Take 1 tablet PO prior to infusion or as directed OR			
Diplientiyaramine	☐ 50mg	\square Inject contents of 1 vial IV prior to infusion or	as directed		
\square Methylprednisolone	☐ 40mg ☐ 100mg	☐ Inject contents of 1 vial IV prior to infusion or as directed			
- Wethyrpreumsolone	☐ 125mg	125mg ☐ Other: Inject 100mg IV 30 minutes prior to in			
<u> </u>					
INFUSION REACTION ORDERS					
Mild reaction protocol:					
☐ Diphenhydramine 25mg IV, one time, for pruritus.					
If symptoms worsen, see orders for moderate to severe reactions.					
Moderate reaction protocol:					

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Date: ____

□ Acetaminophen 650mg PO, one time, for	pyrexia or rigors					
oximes Diphenhydramine 50mg IV, one time, for	pruritus or urticaria					
☑ Methylprednisolone 125mg IV, one time, for respiratory or neurologic symptoms						
If symptoms worsen, see interventions for se	evere reactions					
Severe reaction protocol: (Call 911 if initiated):						
☐ Titrate oxygen via continuous flow per nasal cannula or face mask to maintain spO2 of greater than ninety-five percent (>95%)						
☐ Diphenhydramine 50mg IV, one time, for respiratory symptoms, edema, or anaphylaxis						
☑ Methylprednisolone 125mg IV, one time, for respiratory symptoms, edema, or anaphylaxis						
☑ Sodium Chloride 0.9% 500mL IV over 30-60 min, one time, for cardiovascular symptoms						
☑ Epinephrine 0.3mg/0.3mL IM into mis-anterolateral aspect of thigh of anaphylaxis, may repeat x1 in 5-15 minutes if symptoms are not resolved or						
worsen						
FLUSHING & LOCKING ORDERS						
Flushing Protocol (>66lbs/33kg)						
PIV and Midline:		Implanted Port, PICC, Tunneled Catheter, and Non-tunneled Catheter:				
\boxtimes 0.9% Sodium Chloride 2-5mL IV flush before and after each infusion		\boxtimes 0.9% Sodium Chloride 5mL IV flush before infusion/lab draw and 10mL IV flush after infusion/lab draw				
Locking Protocol (>66lbs/33kg)						
PIV and Midline:	PICC:		Implanted Port, Tunneled Catheter, and Non-tunneled Catheter:			
☑ Heparin Sodium 10 units/mL 1mL IV final flush post normal saline flush	☑ Heparin Sodium 10 units/mL 3mL IV final flush post normal saline flush		☑ Heparin Sodium 100 units/mL 3-5mL IV final flush post normal saline flush			
** May substitute Dextrose 5% in Water, or alternative, for 0.9& Sodium Chloride, when indicated due to incompatibility with medications bring infused						
SIGNATURE						
We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.						

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

Prescriber Signature

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