TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

COSENTYX®

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)

Name: ______________________ DOB: ______________

Address: ______________________________________

City, State, Zip: ______________________________

Phone: ________________ Alt. Phone: ______________

Email: ____________________ SS#: ________________

Gender: ☐ M ☐ F Weight: ________(lbs) Ht: ______________

Allergies: ____________________________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________________

State License: ________________________________

NPI #: _______________ DEA: ____________________

Address: _____________________________________

City, State, Zip: _______________________________

Phone: _________________ Fax: __________________

Office Contact: ___________________ Phone: ____________

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ______________________________

Plan #: _______________________________________

Group #: ______________________________________

RX Card (PBM): _________________________________

BIN: __________________ PCN: ___________________

Secondary Insurance (If Applicable): ______________________

Plan #: _______________________________________

Group #: ______________________________________

RX Card (PBM): _________________________________

BIN: __________________ PCN: ___________________

CLINICAL INFORMATION

☐ L40.8 Psoriatic Arthritis ☐ M45.9 Ankylosing Spondylitis ☐ Other (specify ICD-10):______________________

Currently on therapy? ☐ Yes ☐ No Active TB ruled out? ☐Yes ☐ No 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 Received: ___________ Date of Last Injection/Infusion: ___________

Medication	Dose/Frequency	QTY/Refills
Cosentyx® IV	☐ **Loading Dose** – 6 mg/kg ☐ Frequency: Once at week 0 ☐ Route: Intravenous (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	QTY: ______________ Refills: ____________

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.

X____ Date: __________________

Prescriber Signature

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