Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

COSENTYX (secukinumab)

PATIENT DEMOGRAPHICS

Patient Name: _____
Date of Birth: _____ M: ☐ F: ☐ Address: _____
Phone: _____ City, State, Zip: _____
Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

☐ **Clinical / Progress Notes, Labs, Tests supporting primary diagnosis**
TB status and date (attach results)
Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Ceterizine 10mg PO
☐ Loratadine 10mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other:

PRIMARY MEDICATION ORDER

Infusion

Dosage _____ lbs
_____ kg

☐ 6 mg/kg (loading dose)
☐ 1.75 mg/kg (maintenance dose)
(maximum maintenance dose 300 mg per infusion)

Frequency

☐ Dose at week 0
☐ Every 4 weeks

Injection

☐ COSENTYX (secukinumab) 300 mg subcutaneous injection
☐ one injection 300 mg ☐ two injections 150 mg
☐ Weeks 0, 1, 2, 3, and 4 andevery 4 weeks thereafter

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____
Practice Name: _____ Phone: _____
Office Contact: _____ Fax: _____
Practice Address: _____
City, State, Zip: _____

Provider Signature: _____ Date: _____