SPRINGSIDE INFUSION

Cosentyx

Patient information

Patient name _____ **DOB** _____

Mobile number _____ **Weight** _____ ☐ kgs ☐ lbs

Diagnosis
☐ Psoriatic arthritis
☐ Ankylosing spondylitis
☐ Non-radiographic axial spondyloqrthrits
☐ Other _____

Allergies ☐ NKDA ☐ _____

Medication instructions

Pre-medications
☐ N/A
☐ Provider prescribed: _____

Medication order

Dose
☐ With loading does: 6 mg/kg given at week 0, followed by 1.75 mg/kg every 4 weeks there after
☐ Without loading dose : 1.75 mg/kg * loading dose optional * max. maintenance dose 300 mg per infusion other
☐ Other _____

Frequency
☐ Every 4 weeks
☐ Other _____

Medication route
☐ IV
☐ Other _____

Lab order (Include frequency)
Please list any labs to be drawn by the infusion clinic:
☐ N/A
☐ _____

Prerequisites
Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative TB test result

Please send to ☐ Columbia, MD ☐ Silver Spring, MD ☐ Bowie, MD ☐ Frederick, MD

Referring provider information

Referring provider name _____ **NPI** _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____