COSENTYX REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

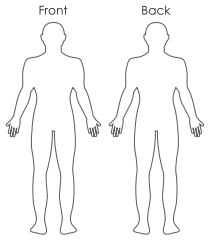
Please Fax Insurance Card(s) both sides

Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ **L40.8** Psoriasis ☐ **L40.59** Psoriatic Arthritis ☐ **M45.9**Ankylosing Spondylitis
☐ **Yes** ☐ **No** Currently on therapy?
☐ **Yes** ☐ **No** Active TB ruled out? Date _____
☐ **Yes** ☐ **No** Active Hep B ruled out? Date_____
Methotrexate contraindicated? ☐ Yes ☐ No Due to social activities?
☐ Yes ☐ No Because Patient is of childbearing age?

Previous Meds	Strength	Duration of Treatment	Not Tolerated	Contraindications
Acitretin				
Adalimumab				
Clobetasol				
Cyclosporine				
Elidel				
Enbrel				
Eucrisa				
Humira				
Leflunomide				
Methotrexate				
Stelara				
Sulfasalazine				
UVA Phototherapy				
UVB Phototherapy				



Scoring Tool Used:
☐ BSA ☐ EASI ☐ ISGA
☐ POEM ☐ SCORAD
_____% or Score: _____

Severity:
☐ Mild (<3% BSA)
☐ Moderate (3-10% BSA)
☐ Severe (>10% BSA)

Location/Affected Areas:
☐ Scalp ☐ Face ☐ Hands ☐ Nails
☐ Groin ☐ Feet ☐ Other _____

PRESCRIPTION

New York Prescribers, please submit prescription on an original NY State prescription blank.

☐ **COSENTYX** ***FOR PLAQUE PSORIASIS***

Starting Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ once weekly for 5 weeks
Each 300 mg dose is given as 2 SQ injections of 150 mg
QTY: 10 injection devices Refills: 0
Treatment Start Date (if applicable) _____

Maintenance Supply ☐ Sensoready® Pen ☐ Prefilled Syringe
Once every 4 weeks
SIG: ☐ Inject 300 mg dose SQ once every 4 weeks
☐ Other: _____
☐ 1 Month ☐ 2 Months ☐ 3 Months
QTY: _____ Refills: _____

☐ **COSENTYX** ***FOR PSORIATIC ARTHRITIS & ANKYLOSING SPONDYLITIS***

With Loading Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
Weeks 0, 1, 2, 3, and 4, then once every 4 weeks
SIG: ☐ Inject 150 mg dose SQ once weekly for 5 weeks
QTY: 10 injection devices Refills: 0
Treatment Start Date (if applicable) _____

Without Loading Dose ☐ Sensoready® Pen ☐ Prefilled Syringe
SIG: ☐ Inject 150 mg dose SQ once every 4 weeks
☐ Other: _____
☐ 1 Month ☐ 2 Months ☐ 3 Months
QTY: _____ Refills: _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS)_____ **Date** _____

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.