Cosentyx

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** Most recent progress notes, Patient Demographic & Insurance Information, Medication List

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: ☐ L40.52 ☐ L40.50 ☐ M45.9 ☐ M45.A6

Other Dx/ICD10: _____

PROVIDER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

☐No Premeds ☐ Other:

PREMEDS

Date of Last Treatment, If Continuation: _____

Patient weight: _____ kg

☐ **Loading Dose:** 6 mg/kg at week 0 then 1.75mg/kg 4 weeks thereafter
Total loading dose: _____ mg

☐ **Maintenance Dose:** 1.75 mg/kg every 4 weeks (Max maintenance dose is 300mg)
Maintenance dose: _____ mg

Administer infusion in 100ml 0.9% NS bag over 30 minutes

Route: ☑ IV