Arthritis, Rheumatic, & Bone Disease Associates
An Affiliate of Trabecular Medical Group

IDYLLIC
infusion treatment center

Cosentyx Request Form

2301 Evesham Road, Building 800, Suite 115
Voorhees, New Jersey 08043
T. (866)497-0905
F. (609)228-9798 attn: Idyllic Infusion Coordinator

DATE:	
REFERRING PROVIDER INFORMATION	
Requesting Provider Name and NPI **Tax ID#**	**Name:** **NPI:** **Tax ID#**
Fax Number	
Practice Contact (Name/Phone number)	
Contact Email	
We will gladly remind your patient to schedule routine follow-up visits with your office. **Return to Referring Provider (frequency): EVERY_____ WKS / MOS**	
PATIENT INFORMATION	
Patient Name	
Date of Birth	/ /
Height in ft/in: **Weight in lbs:**	
Insurance(s): include copies of front and back	
Preferred Treatment Location	☐ Voorhees ☐ Moorestown ☐ Wall/Manasquan ☐ Sewell ☐ Hamilton ☐ Galloway
Primary Care Physician (Name / Phone Number)	PCP Name: PCP Phone Number:

The referring provider is the primary provider responsible for medication management, labs, scripts, and the patient's treatment plan.

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Name (last, first) _____DOB: _____

Diagnosis:
□ L40.0 Plaque Psoriasis
□ L40.5 Psoriatic Arthritis
□ L40.54 Psoriatic juvenile arthropathy
□ M45.0 Ankylosing Spondylitis
□M45.A Non-Radiographic Axial Spondyloarthritis
□ Other ICD-10-CM Code(s): _____
Secondary Diagnosis/Special Areas or Manifestations (optional) _____

Please answer all questions and provide supporting documentation.

1. Has the patient participated in a COSENTYX clinical trial? □ Yes □ No
2. The patient has previously been treated with a biologic for the diagnosed condition. □ Yes □ No

If the patient has been treated with a biologic or another therapy, please answer the following questions:

1. Excluding COSENTYX, does this patient have a contraindication, intolerance, or allergy to Cimzia®, Enbrel®, Humira®, Remicade®, Simponi®, Stelara®, Taltz®, or other biologic treatments, or to phototherapy, methotrexate, sulfasalazine, NSAIDs (diclofenac, ibuprofen, etc)? □ Yes □ No

2. Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments? □ Yes □ No

   If **YES**, please indicate which drug(s):
   □ Cimzia® □ Enbrel® □ Humira® □ Otezla® □ Remicade® □ Rinvoq® □ Simponi®
   □ NSAIDs (diclofenac, ibuprofen, etc) □ Skyrizi® □ Stelara® □ Taltz® □ Tremfya® □ Phototherapy
   □ Methotrexate □ Sulfasalazine □ Other:_____

3. Excluding COSENTYX, does this patient have documented efficacy failure of adequate trial on NSAIDs, DMARDs, or other treatments? □ Yes □ No

For all patients:

- OUR OFFICE WILL PROVIDE & DISPENSE ALL REQUIRED MEDICATIONS
- Does the patient have a history of anaphylaxis? _____
- Is this patient ambulatory?
  - If no, is a wheelchair required _____
- Please include a copy of a prescription. Prescription should include standard information as well as specific instructions if loading doses of desired RX is required. ** NOTE ** Please do NOT provide a prescription to the patient as they may become confused and attempt to fill at their local/specialty pharmacy.
- *Our office will obtain all necessary prior authorizations required and any copay assistance if qualified.*
- Please notify your patient that our office will contact them when we are ready to schedule. They do NOT need to call our office to set up an appointment.
- Please notify our office if medication will be discontinued.

❒ Patient has been educated by the ordering provider on medication.

Ordering Provider Signature _____