Referral Status:		MRN:	
☐	New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:			

Cosentyx® (secukinumab) Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	L40.5_____-Psoriatic Arthritis (PsA)	☐	M45.A_____ -Non-Radiographic Axial Spondyloarthritis (nr-axSpaA)
☐	M45._____ - Ankylosing spondylitis (AS)		
☐	_____ -Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	TB screening prior to and during therapy
6	

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE:Patient may be ineligible to receive secukinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

*Per FDA labeling

IV

Diphenhydramine	☐	25mg	☐	50mg		
Methylprednisolone	☐	40mg	☐	125mg	☐	Other:
Famotidine	☐	20mg	☐	40 mg		
Other:	☐					

PO

Acetaminophen	☐	325mg	☐	500mg	☐	650mg	☐	1000mg
Famotidine	☐	20mg	☐	40mg				
Diphenhydramine	☐	25mg	☐	50mg				
Fexofenadine	☐	60mg	☐	180mg				
Cetirizine	☐	10mg						
Loratadine	☐	10mg						
Other:	☐							

MEDICATION:

☑ Cosentyx® (secukinumab) diluted in 50 to 100mL NS over 30 minutes via IV infusion per protocol. When infusion is complete, flush the line with 50mL of 0.9% NS at final infusion rate.

DOSE/FREQUENCY:

☐ **Induction:** 6mg/kg diluted in 100mL NS at week 0, then 1.75mg/kg every 4 weeks thereafter.

☐ **Maintenance:** 1.75mg/kg every 4 weeks

>52kgs: diluted in 100mL NS

</=52kgs: diluted in 50mL NS

☐ **Other Dose/Frequency:**_____

_____

SPECIAL/LAB ORDERS:

_____

_____

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **Patient demographics - address, phone number, SS#, etc.**
- [ ] **Insurance information - copy of the card(s) if possible**
- [ ] **Plan of Treatment/Orders**
- [ ] **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- [ ] **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com