Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

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		**PO**	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg ☐ 1000mg
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:		Famotidine	☐ 20mg	☐ 40mg	
	Famotidine	☐ 20mg	☐ 40 mg			Diphenhydramine	☐ 25mg	☐ 50mg	
	Other:	☐				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	