



A Carelon Company

# COSENTYX (SECUKINUMAB) INFUSION ORDERS

**P:** 877-365-5566 | **F:** 855-889-2946

**PATIENT INFORMATION** Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

Allergies: \_\_\_\_\_

<b>Diagnosis Code ICD-10 (required):</b>	<b>Diagnosis Description:</b>
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Treatment Date:

**PHYSICIAN INFORMATION**

Prescriber Name:	Phone:	Fax:
Office Contact:	Email:	
Address:	City:	State: ZIP:
NPI #:	DEA#:	Tax ID:

**INSURANCE INFORMATION (or attach copy of cards)**

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

**PRESCRIPTION INFORMATION (or attach a copy of the prescription)**

Drug	Dosing	Refills
<b>Cosentyx IV</b> (secukinumab)	<input type="checkbox"/> 6mg/kg IV at week 0, followed by 1.75mg/kg IV every 4 weeks thereafter <input type="checkbox"/> 1.75mg/kg IV every 4 weeks <input type="checkbox"/> Other: _____ <b>Max maintenance dose (1.75mg/kg) is 300mg</b>	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____

Other orders: \_\_\_\_\_

Lab Orders: \_\_\_\_\_ Lab frequency: \_\_\_\_\_

TB QFT screening yearly (optional)

Required labs to be drawn by:  Paragon  Referring Provider

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.  Dispense as written

**PRESCRIBER SIGNATURE** By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Prescriber Signature: X**

**Date:**

**PATIENT INFORMATION**

Name:

DOB:

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
  - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
- Include labs and/or test results to support diagnosis (attach results)
  - CRP and/or ESR
  - Other applicable diagnostic testing and/or labs
- If applicable - Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_. If patient is switching to biologic therapies, please perform a wash-out period of \_\_\_\_\_ weeks prior to starting Cosentyx.
- Other medical necessity: \_\_\_\_\_

**REQUIRED PRE-SCREENING**

- TB screening test completed within 12 months - attach results**
  - Positive**  **Negative**