Secukinumab (Cosentyx IV)

Provider Order Form rev. 7/22/2024

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Psoriatic Arthritis: Ankylosing Spondylitis: Plaque Psoriasis:

Non-radiographic axial spondylarthritis: Enthesitis-related Arthritis:

Other: Description:

THERAPY ADMINISTRATION

☐ Induction: administer secukinumab (Cosentyx IV) 6mg/kg = _____ mg IV over 30mins at week 0

☐ Maintenance: administer secukinumab (Cosentyx IV) 1.75mg/kg = _____ mg IV over 30mins every 4 weeks.

(Max maintenance dose cannot exceed 300mg per infusion)

☑ Flush IV line with 50ml 0.9% NS after each infusion

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO

☐ Loratadine 10mg PO

☐ Pepcid 20mg ☐ PO / ☐ IVP

☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP

☐ Solumedrol ☐ 40mg / ☐ 125mg IVP

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs or symptoms of illness/active infection or cough, night sweats, weight loss
- Positive TB test
- Recent live vaccinations
- Signs or symptoms of inflammatory bowel disease
- Signs or symptoms of Eczematous Eruptions

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications

Required Labs: Negative TB within 12 months

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.