Infusion Solutions Inc.
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COSENTYX (secukinumab) ORDER FORM

PATIENT NAME:_____ DOB:_____ WT:_____ HT:_____

ALLERGIES:_____

Does the patient have a history of Crohn's Disease? ☐NO ☐YES (if yes, monitoring recommended due to risk of exacerbations)

DIAGNOSIS

HAS THE PATIENT PREVIOUSLY RECEIVED: COSENTYX (secukinumab) ☐NO ☐YES

BRAND: _____ LAST DOSE DATE: _____

DIAGNOSIS: _____ ICD 10 CODE(S): _____

MEDICATION ORDERS

DOSE/FREQUENCY: Maintenance orders are valid for 1 year. For a shorter duration, indicate here: _____

IV formulation (Ankylosing Spondylitis, Axial Spondyloarthritis, or Psoriatic Arthritis)

☐ 1.75 mg/kg **IV** (max 300 mg) every 4 weeks

☐ Other: _____

Loading dose? ☐NO ☐YES, 6 mg/kg **IV** at week 0

STANDARD ORDERS

ANCILLARY ORDERS:

- Infusion Reaction Management per Infusion Solutions Protocol.
- Alteplase 2mg IV to declot central IV access per Infusion Solutions protocol as needed for occlusion.
- Flush with 0.9% NaCl and/or Heparin 10 u/ml or 100 u/ml per Infusion Solutions protocol.
- Lidocaine 1% - up to 0.2 ml intradermally PRN (may buffer with sodium bicarbonate 8.4% in 10:1 ratio).

NURSING ORDERS:

- If no central IV access, RN to insert peripheral IV.
- Obtain weight before each dose
- Monitor vital signs (temp, HR, RR, BP) before therapy, and every 15-30 minutes or with each rate change.
- If an infusion reaction occurs, decrease rate AND monitor vital signs until symptoms subside. If the reaction persists or worsens, stop the infusion, initiate reaction protocol, and notify provider.
- Observe patient for 30 minutes after completion of therapy.

LABS

LAB ORDERS:

☐ CBC w/diff ☐ LFTs

☐ Other: _____

LAB FREQUENCY:

☐ Every 3 months

☐ Other: _____

REQUIRED DOCUMENTATION

REQUIRED CLINICAL DOCUMENTS:

- Quantiferon Gold lab result for TB screening

RECOMMENDED CLINICAL DOCUMENTS (provide if available):

- Baseline CBC w/diff, CMP, CRP
- Hepatitis B testing or proof of vaccination
- Review that all age-appropriate vaccinations are up-to-date as per current immunization guidelines

SUPPORTING DOCUMENTS:

- Patient demographic and insurance information.
- Copy of front and back of insurance card if available.
- Patient's medication list.
- Supporting clinical notes, including past tried and/or failed therapies.

PROVIDER INFORMATION

PRESCRIBER SIGNATURE (substitution) | *PRESCRIBER SIGNATURE (dispense as written)*

PRINT NAME (FIRST AND LAST) | *DATE*