Infusion Solutions Inc.
Home Infusion & Specialty Pharmacy

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COSENTYX (secukinumab) ORDER FORM

PATIENT NAME: _____ DOB: _____ HT: _____WT: _____
ALLERGIES: _____
DIAGNOSIS: _____ ICD 10 CODE(S): _____

HAS THE PATIENT PREVIOUSLY RECEIVED: **COSENTYX**? ❒NO ❒YES
BRAND RECEIVED: _____ LAST DOSE DATE: _____
Does the patient have Inflammatory Bowel Disease? ❒NO ❒YES (if yes, monitoring recommended due to risk of exacerbations)

DOSE/FREQUENCY:
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
Orders are valid for 1 year. For a shorter duration, indicate here: _____
PREMEDICATION: Given 15 – 30 minutes prior to infusion (not typically indicated)
❒ Cetirizine 10 mg PO ❒ Acetaminophen 500 mg PO
❒ Other: _____

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 15 minutes after completion of therapy.

LAB ORDERS:
❒ CBC w/diff ❒ LFTs
❒ Other: _____

LAB FREQUENCY:
❒ Every 3 months
❒ Other: _____

REQUIRED CLINICAL DOCUMENTS:
- Quantiferon Gold lab result for TB screening

RECOMMENDED CLINICAL DOCUMENTS (provide if available):
- Baseline CBC w/diff, CMP, CRP
- Serologic testing for Hepatitis B and C, HIV
- Pregnancy test
- Review that all age-appropriate vaccinations are up-to-date as per current immunization guidelines

REQUIRED 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.

PRESCRIBER SIGNATURE (substitution permitted)

PRESCRIBER SIGNATURE (dispense as written)

PRINT NAME (FIRST AND LAST)

DATE