

# Cosentyx IV (Secukinumab IV)

Provider Order Form rev. 4/10/2022

## PATIENT INFORMATION

Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_

Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### NURSING

Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

### PRE-MEDICATION ORDERS

acetaminophen (Tylenol)  500mg |  650mg |  1000mg PO

cetirizine (Zyrtec) 10mg PO

loratadine (Claritin) 10mg PO

diphenhydramine (Benadryl)  25mg |  50mg |  PO |  IV

methylprednisolone (Solu-Medrol)  40mg |  125mg IV

hydrocortisone (Solu-Cortef)  100mg IV

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

Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency: \_\_\_\_\_

### THERAPY ADMINISTRATION

**Secukinumab IV** [Cosentyx IV] Please indicate if both loading dose and Maintenance doses are needed.

Loading Dose

• Dose: 6mg/kg

• Frequency: Once at week 0

• Route: Intravenous

[Maintenance doses will be given every 4 weeks thereafter]

Maintenance Dose

• Dose: 1.75mg/kg (maximum maintenance dose 300mg per infusion)

• Frequency: Every 4 weeks

• Route: Intravenous

Infuse over 30 minutes

Flush with 0.9% sodium chloride at infusion completion

Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

Initiate therapy WITH load dose

Initiate therapy WITHOUT load dose

## SPECIAL INSTRUCTIONS

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
Provider Name (Print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date