

Cosentyx IV (Secukinumab IV)

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

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