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Secukinumab IV (Cosentyx IV)

Provider Order Form *rev. 02/01/24*

PATIENT INFORMATION

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

Date: Patient Name: DOB:

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

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVCare Infusion's Nursing Procedures, including reaction management and post- procedure observation

☑ TB status & date (list results here & attach clinicals)

_____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

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)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**