

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Cosentyx<sup>®</sup> (secukinumab) Plan of Treatment

### PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG
Gender:	Allergies:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

L40.5 -Psoriatic Arthritis (PsA)	M45.A -Non-Radiographic Axial Spondyloarthritis (nr-axSpaA)
M45. - Ankylosing spondylitis (AS)	
-Other:	

### REQUESTED DOCUMENTATION:

1 Insurance information	IF NO:	IF YES:
2 Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4 Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5 TB screening prior to and during therapy	THERAPY:	
6		
		<b>Continue current order until insurance approved</b>

### MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive secukinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, and/or surgery.

### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

\*Per FDA labeling

<b>IV</b>	Diphenhydramine	25mg	50mg		<b>PO</b>	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
					Cetirizine	10mg				
					Loratadine	10mg				
					Other:					

### MEDICATION:

Cosentyx<sup>®</sup> (secukinumab) diluted in 50 to 100mL NS over 30 minutes via IV infusion per protocol. When infusion is complete, flush the line with 50mL of 0.9% NS at final infusion rate.

### DOSE/FREQUENCY:

**Induction:** 6mg/kg diluted in 100mL NS at week 0, then 1.75mg/kg every 4 weeks thereafter.

**Maintenance:** 1.75mg/kg every 4 weeks  
**>52kgs:** diluted in 100mL NS  
**<=52kgs:** diluted in 50mL NS

**Other Dose/Frequency:**

### SPECIAL/LAB ORDERS:

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Refills x 12 months unless noted otherwise here:

### NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.



### PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

### PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted