



Secukinumab (Cosentyx)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	Office Phone Number:	Fax Number:
Insurance:	Group Number:	Policy Number:
Hospitalization Status:	Patient Weight (kg):	Height (inches):
<input checked="" type="checkbox"/> Outpatient to Outpatient Infusion Center		
Allergies:		

Send patient demographics/insurance, clinical notes, and test results with orders

Diagnosis Code/Description for treatment

- ☐ Arthropathic psoriasis, unspecified (L40.50)
 ☐ Other psoriasis arthropathy (L40.59)
 ☐ Ankylosing spondylitis of multiple sites in spine (M45.0)
 ☐ Ankylosing spondylitis of unspecified sites in spine (M45.9)
 ☐ Non-radiographic axial spondyloarthritis of unspecified sites in spine (M45.A0)
 ☐ Non-radiographic axial spondyloarthritis of multiple sites in spine (M45.AB)

Laboratory

- ☐ CBC WITH DIFFERENTIAL
 ☐ COMPREHENSIVE METABOLIC PANEL

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port
☒ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)

Premedication

- ☐ DiphenhydrAMINE (Benadryl) 25 MG ORAL ONCE
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE
☐ HydrocortISone Succinate (Solu-Cortef) 100 MG IV PUSH ONCE (J1720 : 100 MG = 1 unit)

Infusion – Secukinumab (Cosentyx) [J3247 : 1 MG = 1 unit]

***Preparation Information: For patients GREATER THAN 52 KG use 100 mL for both loading and maintenance bags. For patients 52 KG or LESS use 100 mL for the loading bag and 50 mL for the maintenance bag.

☐ Loading Dose

Secukinumab (Cosentyx) 6 milligram/kilogram (____ MG) in 0.9% Normal Saline INTRAVENOUS ONCE over 30 minutes using an infusion line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter. Flush with 50 mL of saline after infusion.

☒ Maintenance Dose –(Starts 1 week after loading dose if ordered)

Secukinumab (Cosentyx) 1.75 milligram/kilogram (____ MG) in 0.9% Normal Saline INTRAVENOUS ONCE over 30 minutes using an infusion line containing a sterile, low-protein binding 0.2 or 0.22 micron in-line filter. Flush with 50 mL of saline after infusion. Repeat WEEKLY for 4 weeks. MAX Dose 300 MG.

Infusion Reaction

- ☒ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

- ☒ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE: _____
11132507

TIME: _____

PHYSICIAN'S SIGNATURE