Cosentyx IV (Secukinumab IV)

Infusion Order Form – Page 1 of 1

Preferred Clinic Location

☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
P: (855) 481-8375
F: (512) 233-2288

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:

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
  - Patient has active psoriatic arthritis (PsA)
  - Patient has active ankylosing spondylitis (AS)
  - Patient has active non-radiographic axial spondyloarthritis (nr-axSpA)

Orders

NURSING

☑ Nursing care per Harbor Health Nursing Procedures and Harbor Health Adverse Reaction Management Protocol.

☑ Verify current TB status

LABORATORY

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION

☐ 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

☑ **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 **at least** 0.9% sodium chloride at infusion completion

Provider Name (Print): Provider Signature: Date:

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