RED RIVER HEALTH
Ambulatory Infusion Clinic

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COSENTYX (secukinumab) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Plaque Psoriasis (PsO)
☐ _____ Ankylosing Spondylitis (AS)
☐ _____ Psoriatic Arthritis (PsA)
☐ _____ Hidradenitis Suppurativa
☐ _____ _____ *(other)*

Pre-Medication:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☑ TB Status and Date *(please attach)*

COSENTYX ORDERS:

☐ **Loading Dose:** 6mg/kg IV at week 0 **Pt. weight:** _____ *(ensure unit of measure is noted)*

☐ **Maintenance Dose:** 1.75mg/kg IV every 4 weeks (max dose 300mg per infusion)

☑ Dilute with 100mL 0.9% sodium chloride (50mL 0.9% sodium chloride for maintenance dose and <52kg) & administer IV over 30 minutes

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____