

TN  
100 Covey Drive  
Suite 307  
Franklin, TN 37067



# Secukinumab IV (Cosentyx IV)

## Provider Order Form

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**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: \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

**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)

Total dosages \_\_\_\_\_

Refills \_\_\_\_\_

**NOTES/ADDITIONAL COMMENTS:**

### ORDERING PROVIDER

Signature   X   \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_