SECUKINUMAB (Cosentyx) Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Diagnosis [ ] Psoriatic arthritis [ ] Other: _____

Weight: _____kg Height: _____inches [ ] New treatment
[ ] Transfer – Receiving secukinumab since_____

Negative TB test date _____

Prior to initial therapy: (Provide copies if results not reported in RFGH EMR)

- Pregnancy test if between 14 and 50 years old with gestational potential.
- Hepatits C virus antibody, HIV, C-reactive protein
- Screen for Hepatitis B infection: Hep B surface antigen, Hep B Antibody, Hep B Core Antibody total. .
- TB screen with PPD or IGRA before start of therapy if none in past 12 months.

PRE-MEDICATE (30 minutes before infusion) **or confirm patient has taken prior to arrival**

[ ] acetaminophen 1000 mg PO
[ ] loratadine 10 mg PO
[ ] diphenhydramine 25 mg PO
[ ] Methylprednisolone 40 mg IV
[ ] Hydrocortisone 50 mg IV
[ ] Other:

Secukinumab IV

[ ] Initial – with loading dose - 6 mg /kg at week 0.
Then 1.75 mg /mg (max 300 mg) every 4 weeks

[ ] **Maintenance or omit loading dose**
1.75 mg /mg (max 300 mg) every 4 weeks

Screen patient for symptoms of current infection. Defer treatment and contact prescriber if noted.
Instruct patient to report any symptoms of discomfort or an allergic reaction immediately.
Provide patient with medication guide before administration of each dose. Allow the patient time to read and ask questions. Document process in chart.
Administer diluted in 100 mls sodium chloride 0.9%.

- For patients weighing < 52 kgs, administer maintenance dose in 50 mls.

Infuse over 30 minutes through a 0.2-micron filter.
Vital Signs: prior to infusion, at 15 minutes, & post infusion. May be discharged if post-infusion vital signs are stable. Instruct patient to seek medical attention if they feel sick or develop a fever, cough, or other signs of infection.

[X] Repeat TB screen with IGRA if no IGRA or PPD in the past 12 months
[ ] CBC and hepatic panel - recommended at 3 to 6 months after initiating therapy.
[ ] Other:

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed#
#If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
Annually: [ ] H&P completed with last year
If new therapy: [ ] Pretreatment lab results [ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .
Contacted provider:_____

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Prep: 7/8/25

Provider signature _____Date_____time_____

If not RFGH credentialed: Printed name_____ Phone # _____

RFGH Co-signature _____

Date_____ time:_____

Patient _____

dob _____ phone #_____