

SECUKINUMAB (Cosentyx) Infusion Order Form

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.
- Hepatitis 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 | ☐ Methylprednisolone 40 mg IV |
| ☐ loratadine 10 mg PO | ☐ Hydrocortisone 50 mg IV |
| ☐ diphenhydramine 25 mg PO | ☐ 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.

☒ **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 - attach:

- ☐ Pretreatment lab results
- ☐ Problem list
- ☐ Current medication and allergies

FAX to RFGH Infusion clinic at 207-858-2404

Contact Infusion Clinic at 207-858-8722

Provider signature _____ Date _____ time _____

Prep: 9/25

Printed name _____ Phone # _____

Patient _____

dob _____ phone # _____