

An Outpatient Department of Trinity Health Oakland  
9406 Village Place Blvd, Brighton, MI 48116  
Phone: 810-844-7373  
Fax: 810-844-7366

## Secukinumab (Cosentyx)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

<b>Patient Name:</b> _____ <b>Patient Address:</b> _____ <b>Patient Phone Number:</b> _____ <b>Date of Birth:</b> ____/____/____ <b>Weight:</b> ____ kg <b>Height:</b> ____ cm <b>Allergies:</b> _____		<b>Primary Insurance:</b> _____ <b>Member ID:</b> _____ <b>Secondary Insurance:</b> _____ <b>Member ID:</b> _____	
<b>Diagnosis</b> <input type="checkbox"/> Arthropathic psoriasis, unspecified (L40.50) <input type="checkbox"/> Ankylosing Spondylitis, unspecified site of spine (45.9) <input type="checkbox"/> Non-radiographic axial spondyloarthritis of unspecified sites of spine (M45.A0) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____		<b>Labs</b> <input type="checkbox"/> CBC w/diff <input type="checkbox"/> Interferon gamma for TB, whole blood <input type="checkbox"/> Other: _____  <b>Frequency</b> <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____	
<b>Date of negative Tuberculosis Screen:</b> _____			
<b>Hold and notify provider:</b> Patient has signs/symptoms of an active infection.			
<b>Secukinumab (Cosentyx)</b>  <input type="checkbox"/> Loading dose: 6 mg/kg at week 0 <input type="checkbox"/> Maintenance dose: 1.75 mg/kg every 4 weeks <input type="checkbox"/> Other: ____ mg/kg every _____  Administer the infusion solution intravenously over a 30-minute period through an infusion line containing a sterile, low-protein binding 0.2 micron filter.			
<b>Pre-Medications and Pre-Protocol</b> (ordered at physician discretion)		<b>Hydration</b> <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other: _____  _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following	
<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____			

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<b>Flushing Protocol as needed for line care</b>	<input type="checkbox"/> <b>Sodium Chloride 0.9%</b> <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL	<input type="checkbox"/> <b>Heparin 100 Units/mL</b> <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL						
<b>Hypersensitivity Panel</b> Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary.	<ul style="list-style-type: none"> <li>• <b>Sodium chloride</b> 0.9% bolus 500 mL once as needed for hypotensive management (SBP &lt;90mmHg)</li> <li>• <b>Acetaminophen</b> 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping</li> <li>• <b>Albuterol</b> 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses</li> <li>• <b>Albuterol HFA</b> inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea</li> <li>• <b>Epinephrine</b> injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses</li> <li>• <b>Famotidine</b> injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Diphenhydramine</b> injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom</li> <li>• <b>Diphenhydramine</b> injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Hydrocortisone</b> sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> </ul>							
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Provider Name: _____</td> <td style="width: 50%;">Provider Signature: _____</td> </tr> <tr> <td>Attending Physician Name: _____</td> <td>Provider NPI: _____</td> </tr> <tr> <td>Office Phone Number: _____</td> <td>Office Fax Number: _____</td> </tr> </table> <p><i>Note: This order is valid for 12 months from date of physician signature.</i></p>			Provider Name: _____	Provider Signature: _____	Attending Physician Name: _____	Provider NPI: _____	Office Phone Number: _____	Office Fax Number: _____
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