

COSENTYX® (secukinumab)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List TB Test
 Clinical/Progress Notes Supporting Dx Most Recent Labs


Primary Diagnosis

-  ICD-10 Code (required): _____ Ankylosing Spondylitis
 Plaque Psoriasis Non-Radiographic Axial Spondylo-arthritis
 Psoriatic Arthritis Other: _____

Pre-Medication

- Per violet health protocol: No standard recommended premedications for COSENTYX 
 Other: _____
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetirizine (Zyrtec) 10 mg PO

Therapy Administration

- Cosentyx 6 mg/kg IV at week 0, followed by 1.75 mg/kg IV every 4 weeks thereafter  MAX. maintenance dose is 300 mg per infusion
 Cosentyx 1.75 mg/kg IV every 4 weeks
 Other: _____

Refills:

- x 1 year Other: _____  Order valid for one year unless otherwise stated

Nursing Orders

- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/ protocol for policy) Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) **Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box**
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration. RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____