ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN	
Allergies/Reactions:	Fax all infusions to: 833-380-8800 Please mark the appropriate infusion center: ❑ Allenmore Infusion Center ❑ DHEC Infusion Center ❑ Auburn Infusion Center ❑ North Spokane Infusion Center ❑ Gig Harbor Infusion Services ❑ North Star Lodge Infusion Center ❑ Puyallup Infusion Center
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Secukinumab (Cosentyx)

Patient Name:_____Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ □ May leave message

Diagnosis: □ Psoriatic Arthritis □ Ankylosing Spondylitis □ Non-Radiographic Axial Spondyloarthritis

ICD -10 Code: □_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs and documentation ***If required documentation not received with order, scheduling of treatment will be delayed until complete information is available***

*Immunization with live-attenuated or live vaccines is not recommended during treatment.

Baseline labs required:

● Latent TB testing Date:_____/_____/_____ Results:_____

Maintenance Labs Required:

• none listed

Treatment Regimen:

Secukinumab (Cosentyx): Infuse IV over 30 minutes

□ with loading dose= 6 mg/kg given at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter

□ without loading dose= 1.75 mg/kg every 4 weeks

**Total doses exceeding 300mg per infusion are not recommended for the 1.75 mg/kg maintenance dose

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.

Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

• Consult MultiCare hypersensitivity guideline for treatment management

• Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: □ Yes □ No (if yes, please send DOCUMENTATION of consent with order)

_____	_____	_____	_____
Provider Signature	Print Name	Date	Time

Orders expire in 12 months**

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-Printed Order

PSORIATIC ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS

MultiCare

60-0694-3 (Rev. 9/24)

EXAM NOTES:

PROCEDURE:

Nurse Signature | Print Name

Provider signature | Date

ORDERS:

Medication	Sig	Disp	Refill	Comments

CPT Code - Level of Service

ESTABLISHED — Please circle one

1. 99211 2. 99212 3. 99213 4. 99214 5. 99216

CPT Code - Level of Service

NEW

1. 99201 2. 99202 3. 99203 4. 99204 5. 99206

ICD Code - 9 CODE

DIAGNOSTIC

1. 2. 3. 4. 5.

❑ FOLLOW UP PRN ❑ RETURN VISIT ❑ PHONE CALL