

**ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN**

**Allergies/Reactions:**

Fax all infusions to: 833-380-8800  Allenmore Infusion Center  DHEC Infusion Center  
 Please mark the appropriate  Auburn Infusion Center  North Spokane Infusion Center  
 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

**ICD -10 Code:**

**Diagnosis:**  Psoriatic Arthritis  Ankylosing Spondylitis  \_\_\_\_\_  
 Non-Radiographic Axial Spondyloarthritis

**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**



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