Ascension Rx

Secukinumab (Cosentyx & Biosimilars) Infusion Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☐ Baseline
    - ☐ CBC with Differential
    - ☐ CMP
    - ☐ HIV
    - ☐ TB screening (QuantiFERON or alternative)
    - ☐ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
    - ☐ Hepatic Function Panel
  - ☐ Maintenance (every _____)
    - ☐ CBC with Differential
    - ☐ Hepatic Function Panel
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Live vaccines should not be given concurrently
Monitor patients for signs & symptoms of Inflammatory Bowel Disease (IBD), including patients without a history of IBD.

Nursing Orders

- ☑ Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Ascension Rx

Secukinumab (Cosentyx & Biosimilars) Infusion Order Form

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____
- ☐

IV Site Orders

- ☑ Follow standard protocol for IV site management
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
  - ☑ Start peripheral IV or access central line for infusion
  - ☑ Sodium chloride 0.9% 10 mL flush to IV site as needed
  - ☑ Heparin 50 units/5 mL flush to IV site as needed (central line only)
  - ☑ Heparin 500 units/5 mL flush to IV site as needed (central line only)
  - ☑ May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

Medication Orders

Loading Dose:

☐ Secukinumab 6 mg/kg (_____ mg) IV once over 30 minutes

Maintenance Dose:

☐ Secukinumab 1.75 mg/kg (_____ mg) IV once over 30 minutes every 4 weeks (max dose 300 mg)

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

- ☐ Payer-mandated substitution
- ☐ Financial stewardship
- ☐ Patient access / hardship

Pharmacy may adjust dose ±10% of ordered dose per approved protocol. Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

9/18/2026

Ascension Rx

Secukinumab (Cosentyx & Biosimilars) Infusion Order Form

Infuse through a 0.2 micron low protein binding inline filter. Flush line with 50 mL 0.9% Sodium Chloride after each infusion.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated