ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:	□ Puyallup Infusion Center - Fax: 253-697-5066 □ Allenmore Infusion Services - Fax: 253-864-4052 □ Auburn Infusion Services - Fax: 253-876-8282	□ Gig Harbor Infusion Services-Fax: 253-503-8069 □ DHEC Infusion Center - Fax: 509-755-5845 □ North Spokane Infusion Center - Fax: 509-232-2531
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 (12/23)

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