



Cosentyx (secukinumab) IV Infusion Order Form

Phone: 614-407-1621 Fax: 614-413-3877

orders@fusiondriphydration.com

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / ____
- **Phone:** _____ **Email:** _____
- **Address:** _____
- **Weight:** _____ lb/kg
- **Allergies:** ☐ NKDA ☐ _____
- **Treatment Status:** ☐ New ☐ Continued **Last Treatment Date:** ____ / ____ / ____

Diagnosis (ICD-10 Selection)

- ☐ L40.50 – Arthropathic psoriasis, unspecified
- ☐ M45.9 – Ankylosing spondylitis
- ☐ M45.A0 – Non-radiographic axial spondyloarthritis
- ☐ Other: _____ **ICD-10 Code:** _____

Infusion Order

- **Loading Dose:**
 - ☐ 6 mg/kg IV at Week 0
- **Maintenance Dose:**
 - ☐ 1.75 mg/kg IV every 4 weeks
 - ☐ Maximum maintenance dose: 300 mg per infusion
 - ☐ Infuse over 30 minutes
- **Refills:** ☐ None ☐ 12 months ☐ Other: _____

Line Use & Access

- ☐ Start PIV ☐ Access CVC ☐ Use PICC Line
- ☒ Flush per standard infusion protocol

Adverse Reaction & Anaphylaxis Orders

- ☒ Fusiondrip Hydration & Wellness Protocol (fusiondriphydration.com)
- ☐ Other – please fax preferred reaction orders to 614-413-3877

Premedication (Optional)

- ☐ Acetaminophen: ☐ 500 mg ☐ 650 mg ☐ 1000 mg ☐ PO
☐ Diphenhydramine: ☐ 25 mg ☐ 50 mg ☐ PO ☐ IV
☐ Methylprednisolone: ☐ 40 mg ☐ 125 mg ☐ IV
☐ Cetirizine: ☐ 10 mg ☐ PO
☐ Other: _____ **Dose:** _____ **Route:** _____

Laboratory Monitoring

- ☐ CBC ☐ CMP ☐ CRP ☐ TB Screening
☐ Other: _____
Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other: _____
☐ Physician office will order labs only

Clinical Documentation Checklist

- ☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

Ordering Provider & Demographics

- **Name:** _____
- **NPI:** _____ **License #:** _____
- **Contact:** _____ **Phone:** _____ **Fax:** _____
- **Email:** _____
- **Signature:** _____ **Date:** ____ / ____ / ____