



Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

# COSENTYX IV MEDICATION ORDER

This order is only for the infusion version of Cosentyx, not the injectable version.

Patient's Name (Last, First, Middle) \_\_\_\_\_ DOB \_\_\_\_\_

Patient's height in feet and inches \_\_\_\_\_ Patient's weight in pounds \_\_\_\_\_

### ■ Diagnosis

- L40.50 Arthropathic psoriasis, unspecified
- L40.59 Other psoriatic arthropathy
- M45.0 Ankylosing spondylitis of multiple sites in spine
- M45.9 Ankylosing spondylitis of unspec sites in spine
- M45.AO Non-radio. axial spondyl. of unspec spine
- M45.AB Non-radio. axial spondyl. of mult sites spine

### ■ Details Needed for Approval

#### For psoriatic arthritis (PsA):

- Does the patient have active PsA? \_\_\_\_\_ If yes, circle severity: Mild Mild-to-Moderate Severe
- Has the patient previously received a biologic or targeted synthetic drug (e.g. Otezla) for this condition? \_\_\_\_\_ If yes, please document medication(s) used, duration of use and reason(s) for discontinuation in the chart notes.
- If the patient had inadequate response or intolerance to methotrexate, leflunomide, acitretin, DMARD or other therapies, please document in the notes including detailing the inadequate response or specific intolerance.
- If the patient has a clinical reason to avoid methotrexate, cyclosporin or acitretin? If yes, please document in the notes including specific details for each such medication.
- Does the patient have predominantly axial disease? \_\_\_\_\_
- For patients continuing on Cosentyx IV for PsA, please clearly document the improvement from baseline re the number of swollen and tender joints, dactylitis, enthesitis, axial disease, skin condition and nail involvement.

#### For ankylosing spondylitis (AS) and non-radiographic axial spondylarthritis (nr-axSpA):

- Has the patient previously received a biologic or targeted synthetic drug (e.g. Rinvoq, Zeljanz) for this condition? \_\_\_\_\_ If yes, please document the medications and the patient's response in detail in the chart notes.
- Has the patient had an inadequate response, intolerance of, or contraindication to any NSAIDs, DMARDs, sulfasalazine or methotrexate? \_\_\_\_\_ If yes, please document the medications and their dosage (esp. if max dose was reached) and the patient's response, reaction to or contraindication in detail in the chart notes.
- For patients continuing on Cosentyx IV for AS or nr-axSpA, please clearly document the improvement from baseline of functional status, or total spinal pain, or inflammation (e.g. morning stiffness) in the chart notes.
- If the patient has elevated CRP and/or evidence of sacroiliitis on MRI, please provide results and reports.

### ■ Cosentyx IV (secukinumab) Medication Order

Select one or both doses as required:

- Loading dose: 6mg/kg IV at week 0. If maintenance dosing is also ordered, it begins every 4 weeks thereafter.
- Maintenance dose: 1.75 mg/kg IV every 4 weeks (max 300mg per treatment) for 1 year.

Administer according to manufacturer's instructions. Post infusion flush line. Check vitals and monitor for signs and symptoms of an infusion reaction at start, throughout infusion, and after completion.

### ■ Rescue Management in case of Infusion Therapy Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Stop medication infusion and start normal saline infusion at 50 ml/hr. Call ordering provider to report reaction.
- Follow standing reaction orders, including Diphenhydramine, Methylprednisolone, Albuterol and oxygen as needed. Famotidine 20mg IVP for minor cutaneous reactions which do not respond to diphenhydramine.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

### ■ Ordering Provider Authorization

Provider Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Indiv. NPI #: \_\_\_\_\_ License: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_ Direct Phone to Contact Person: \_\_\_\_\_

**FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.**