Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

COSENTYX® (SECUKINUMAB) PRESCRIBER ORDER FORM

Patient Name:	Date of Birth:	Gender:
Address:		
Phone:	**Height:** ☐ inches ☐ cm	**Weight:** ☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Allergies: ☐ NKDA OR (List):

TB Status:	☐ PPD (negative) – date: _____	☐ Active TB
	☐ Last chest x-ray – date: _____	☐ Unknown
	☐ Quantiferon or T Spot Assay result and date: _____	☐ Past positive TB infection, course taken: _____

Cosentyx® (Secukinumab) Prescription

Cosentyx® (Secukinumab) refill as directed x 1 year

Adult

☐ IV: Infuse 6mg/kg at Week 0, followed by 1.75 mg/kg every 4 weeks thereafter (maximum maintenance dose 300mg per infusion)
☐ IV: Infuse 1.75mg/kg every 4 weeks (maximum 300mg per infusion) – no loading dose
☐ SUBQ: Inject 150mg at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter
☐ SUBQ: Inject 150mg every 4 weeks – no loading dose
☐ SUBQ: Inject 300mg at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter
☐ SUBQ: Inject 300mg every 4 weeks – no loading dose

Pediatric

Weight	Dose
☐ Weight between 15-50 kg	Inject 75mg at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter
☐ Weight >/= 50kg	Inject 150mg at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter
☐ Weight between 30-90 kg (Hidradenitis Suppurativa only)	
☐ Weight >/= 90kg (Hidradenitis Suppurativa only)	Inject 300mg at Weeks 0, 1, 2, 3, and 4 and every 4 weeks thereafter

Other: _____

Anaphylaxis Kit

Does this patient require an anaphylaxis kit?

☐ Yes, with 1st dose ☐ Yes, with all doses ☐ No

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis.

Pre-Medication Orders

☐ Other: _____

IV Flush Orders

- Peripheral: NS 3 to 5 mL pre-/post-use.
- Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.
☐ Other: _____

Skilled nurse to administer doses by the ordered route (IV or SUBQ). For SUBQ administration, nurse to assess, administer, and/or teach self-administration where appropriate, and provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:		**NPI:**
City, State:	**Zip:**	**Office Contact:**

