

**Cosentyx (secukinumab) ATU Order Set**

Contraindications – hypersensitivity to secukinumab or its inactive ingredients

= Optional Order     = Routine Order    (Cross out and initial **BULLETED ORDERS** that do not apply)

**ORDERS**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Diagnosis Code: (ICD-10) \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ (kg)

Allergies: \_\_\_\_\_

Last TB Test: Date \_\_\_\_\_ TB Test Result \_\_\_\_\_ *\*Initial TB Test required prior to first dose. Any subsequent testing optional, and to be ordered and evaluated by provider.*

**PRE-MEDICATIONS**  
 When ordering a pretreatment medication, please select appropriate formulation. Give 30-60 minutes prior to treatment.

Acetaminophen - 650 mg, Oral: Tab.  
 Methylprednisolone (Solu-medrol) 40 mg IV Push.  
 Famotidine – 20 mg, oral. Tab.  
 Famotidine – 20 mg, IV Push. Injection.  
 Other \_\_\_\_\_

**MEDICATIONS**

**Initial**  
 Cosentyx (secukinumab) 6mg/kg IV once

**Maintenance**  
 Cosentyx (secukinumab) 1.75mg/kg IV, every 4 weeks (Max dose 300 mg)

**Administration and Nursing Considerations:**

- Use 0.2 or 0.22 micron in-line filter
- Monitor for infusion reactions during infusions
- Infuse over 30 minutes

**Treatment for Adverse Drug Reactions** (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". (Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O<sub>2</sub> PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO<sub>2</sub> every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

**By signing this document, the provider confirms that the patient is up to date on vaccinations and no live vaccines have been given within 4 weeks of starting treatment.**

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

Provider Name and Credentials (please print): \_\_\_\_\_ Time: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

