

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 tubing
- 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 O₂ PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO₂ 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: _____

