ILARIS

(canakinumab)

FAX to + 1 208.963.3245 or Email to intake@infusionspecialists.org To ensure processing of your order, please complete all fields.

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:________________lbs or ____________kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Most Recent Labs
- Medication List
- Neg TB Test

PRIMARY DIAGNOSIS

Gout:

☐ M1A.9xx0 Chronic gout, unspecified, without tophi

☐ M1A.9xx1 Chronic gout, unspecified, with tophi

Still's Disease:

☐ M08.20 SJIA

☐ M06.1 AOSD

Periodic Fever Syndrome:

☐ M04.1 (FMF, HIDS/MKD, TRAPS, and CAPS)

☐ Other: ____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Ilaris

☐ Provider Prescribed: ____

PRIMARY MEDICATION ORDER

Gout

☐ Ilaris 150mg subQ every 12 weeks x ______doses

Still's Disease: SJIA and AOSD

☐ Ilaris 4mg/kg (mg) subQ every 4 weeks. Max of 300mg

PFS: FMF, HIDS/MKD, and TRAPS

☐ Weight >40kg: Ilaris 150mg subQ every 4 weeks

☐ Weight 15kg – 40kg: Ilaris 2mg/kg (_________mg) subQ every 4 weeks

PFS: CAPS (FCAS and WMS)

☐ Weight >40kg: Ilaris 150mg subQ every 8 weeks

☐ Weight 15kg - 40kg: Ilaris 2mg/kg (_________mg) subQ every 8 weeks

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:____________________________

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

______________________________________ Provider Signature

____________________ Date