

ILARIS

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Results

PATIENT

Referral Status: ☐ New ☐ Updated ☐ Renewal

Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

PRESCRIBER

Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL

Diagnosis: ☐ M04.1 ☐ M04.2 ☐ M06.1 ☐ M08.2 ☐ M08.9 ☐ M10. ☐ Other: _____

Allergies: _____ Weight: _____ kg ☐ lbs Height: _____ cm ☐ in

CBC Completed: ☐ Yes ☐ No CMP/LFTs Completed: ☐ Yes ☐ No TB Test: ☐ Positive ☐ Negative

TREATMENT

ILARIS (canakinumab)

Route: Subcutaneous Injection

Dose: ☐ Still's Disease: SJIA and AOSD Dose:
4mg/kg (max 300mg) every 4 weeks ☐

☐ PFS: FMF, HIDS/MKS, and TRAPS ☐

☐ ≤40kg Dose: 2mg/kg every 4 weeks ☐

☐ Dose can be increased to 4mg/kg
every 4 weeks ☐

☐ >40kg Dose: 150mg every 4 weeks ☐

☐ Dose can be increased to 300mg
every 4 weeks ☐

☐ PFS: CAPS (FCAS and MWS) ☐

☐ 15 - 40kg Dose: 2mg/kg every 8 weeks ☐

☐ Dose can be increased to 3mg/kg ☐

☐ >40kg Dose: 150mg every 8 weeks ☐

☐ Gout Flare : 50mg SubQ x 1 dose

Quantity: _____ Refills: _____

Premedication Protocol: (Not Usually Indicated)

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

☒ Center will use anaphylactic and hypersensitivity
protocol established by Restore Health

Special Instructions: _____

Provider Signature: _____

Date: _____

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