RESTORE HEALTH
INFUSION AND WELLNESS

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: _____