RESTORE HEALTH
INFUSION AND WELLNESS

ILARIS

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

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

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

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

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

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

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

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 INFORMATION

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: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____