

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: _____

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