

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



Canakinumab (Ilaris)

Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

<p>OBSERVATION (PLEASE SELECT BELOW)</p> <p><input type="checkbox"/> Patient is required to stay for 30 minutes observation period</p> <p><input type="checkbox"/> Patient is NOT required to stay for observation time</p> <p><input type="checkbox"/> Other: _____</p> <p>SPECIAL INSTRUCTIONS</p> <div></div>	<p>THERAPY ADMINISTRATION</p> <p>Canakinumab (Ilaris)</p> <p>For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis.</p> <p><input type="checkbox"/> 4mg/kg (with a max of 300mg) for patients with a body weight greater than or equal to 7.5kg subcutaneous every 4 weeks</p> <p><input type="checkbox"/> Other _____</p> <p>For Cryopyrin-Associated Periodic Syndromes (CAPS)</p> <p><input type="checkbox"/> 150mg for patients with body weight greater than 40kg subcutaneous every 8 weeks</p> <p><input type="checkbox"/> 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg subcutaneous every 8 wks</p> <p><input type="checkbox"/> Other _____</p> <p>For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever</p> <p><i>Body weight less than or equal to 40kg</i></p> <p><input type="checkbox"/> 2mg/kg subcutaneous every 4 weeks</p> <p><input type="checkbox"/> 4mg/kg subcutaneous every 4 weeks - consider if clinical response not adequate. <input type="checkbox"/> Other _____</p> <p><i>Body weight greater than 40kg</i></p> <p><input type="checkbox"/> 150mg subcutaneous every 4 weeks</p> <p><input type="checkbox"/> 300mg subcutaneous every 4 weeks - consider if clinical response not adequate.</p> <p>Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed) <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Total Doses _____ <input type="checkbox"/> Refills _____</p>
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NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____