Princeton / Somerset New Jersey
49 Veronica Avenue
Suite 202
Somerset, NJ 08873

Office: 212-803-3339 Fax : 646-768-8600

Canakinumab (Ilaris)

Provider Order Form

Date: ____________________

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS
☐New Referral ☐Referral Renewal ☐Medication/Order Change ☐Benefits Verification Only ☐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:

OBSERVATION (PLEASE SELECT BELOW)

- ☐ Patient is required to stay for 30 minutes observation period
- ☐ Patient is NOT required to stay for observation time
- ☐ Other: ______________________________

SPECIAL INSTRUCTIONS

THERAPY ADMINISTRATION

Canakinumab (Ilaris)

For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis.

- ☐ 4mg/kg (with a max of 300mg) for patients with a body weight greater than or equal to 7.5kg subcutaneous every 4 weeks
- ☐ Other ___________

For Cryopyrin-Associated Periodic Syndromes (CAPS)

- ☐ 150mg for patients with body weight greater than 40kg subcutaneous every 8 weeks
- ☐ 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg subcutaneous every 8 wks
- ☐ Other ___________

For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever

Body weight less than or equal to 40kg

- ☐ 2mg/kg subcutaneous every 4 weeks
- ☐ 4mg/kg subcutaneous every 4 weeks - consider if clinical responsenot adequate.
- ☐ Other _____

Body weight greater than 40kg

- ☐ 150mg subcutaneous every 4 weeks
- ☐ 300mg subcutaneous every 4 weeks - consider if clinical response not adequate.

Refills:☐Zero / ☐for 12 months /☐ ________________________ (if not indicated order will expire one year from date signed)

☐ Other _____

☐ Total Doses______ ☐ Refills ________

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** ______________________________ Date ______________

Provider ______________________ Phone ____________ Fax ______________