

Chicago Illinois  
4711 Golf Road  
Suite 900  
Skokie, IL 60076



# 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: _____

**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 response not 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 \_\_\_\_\_