

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



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 _____