

# ILARIS (CANAKINUMAB) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_  
 New Start Therapy |  Continuation of Therapy & Date of last dose (if applicable): \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

- Periodic Fever Syndromes:
- Cryopyrin-Associated Periodic Syndromes (CAPS), in adults and children 4 years of age and older, including:
    - Familial Cold Auto-inflammatory Syndrome (FCAS), ICD 10: M04.02
    - Muckle-Wells Syndrome (MWS), ICD 10: M04.02
    - Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) in adult and pediatric patients, ICD 10: M04.01
    - Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) in adult and pediatric patients, ICD 10: M04.01
    - Familial Mediterranean Fever (FMF) in adult and pediatric patients, ICD 10: M04.01
- Active Still's Disease, including Adult-Onset Still's Disease (AOSD) M06.1 and Systemic Juvenile Idiopathic Arthritis (SJIA) in patients 2 years of age and older, ICD 10: M08.2
- Gout flares in adults in whom non-steroidal anti-inflammatory drugs (NSAIDs) and colchicine are contraindicated, are not tolerated, or do not provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate, ICD 10: M10. \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics     Labs and tests supporting diagnosis     Office/progress notes

## PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV     Methylprednisolone (Solu-Medrol) 125 mg IVP  
 Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO  
 Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_

**FAX NUMBERS:**

- |                                           |                                           |                                           |                                           |                                           |
|-------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> CT: 203.433.0621 | <input type="checkbox"/> MA: 413.296.8482 | <input type="checkbox"/> NC: 919.984.8698 | <input type="checkbox"/> NY: 631.250.6020 | <input type="checkbox"/> SC: 864.973.6279 |
| <input type="checkbox"/> FL: 904.877.9270 | <input type="checkbox"/> MD: 240.224.8607 | <input type="checkbox"/> NH: 603.217.5371 | <input type="checkbox"/> OH: 937.871.4594 | <input type="checkbox"/> VA: 703.202.0499 |
|                                           | <input type="checkbox"/> ME: 207.407.7272 | <input type="checkbox"/> NJ: 201.581.4521 | <input type="checkbox"/> PA: 610.273.5998 |                                           |

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## MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Ilaris	<p><b>CAPS</b></p> <p><input type="checkbox"/> &gt;40kg: 150 mg every 8 weeks</p> <p><input type="checkbox"/> 15-40 kg: 2mg/kg sub-q every 8 weeks.</p> <p><input type="checkbox"/> Other: _____mg</p>	Subq Injection
	<p><b>TRAPS, HIDS/MKD, and FMF:</b></p> <p><input type="checkbox"/> Greater than 40kg: 150 mg every 4 weeks.</p> <p><input type="checkbox"/> Greater than 40kg: 300 mg every 4 weeks (lack of clinical response)</p> <p><input type="checkbox"/> &lt;40kg: 2mg/kg every 4 weeks</p> <p><input type="checkbox"/> &lt;40kg: 4mg/kg every 4 weeks (lack of clinical response)</p>	
	<p><b>Still's Disease (AOSD and SJIA)</b></p> <p><input type="checkbox"/> &gt;7.5kg: 4mg/kg every 4 weeks (max of 300mg)</p>	
	<p><b>Gout Flares</b></p> <p><input type="checkbox"/> 150mg sub-q (12 weeks between doses if repeated)</p>	

## LABS / SPECIAL INSTRUCTIONS

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