

# ILARIS (CANAKINUMAB) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_ kg  
 Allergies: \_\_\_\_\_

## 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: M04.2
    - Muckle-Wells Syndrome (MWS), ICD 10: M04.2
    - Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) in adult and pediatric patients, ICD 10: M04.1
    - Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) in adult and pediatric patients, ICD 10: M04.1
    - Familial Mediterranean Fever (FMF) in adult and pediatric patients, ICD 10: M04.1
- 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	<b>CAPS</b> <input type="checkbox"/> >40kg: 150 mg every 8 weeks <input type="checkbox"/> 15-40 kg: 2mg/kg sub-q every 8 weeks. <input type="checkbox"/> Other: _____mg	Subq Injection
	<b>TRAPS, HIDS/MKD, and FMF:</b> <input type="checkbox"/> Greater than 40kg: 150 mg every 4 weeks. <input type="checkbox"/> Greater than 40kg: 300 mg every 4 weeks (lack of clinical response) <input type="checkbox"/> <40kg: 2mg/kg every 4 weeks <input type="checkbox"/> <40kg: 4mg/kg every 4 weeks (lack of clinical response)	
	<b>Still's Disease (AOSD and SJIA)</b> <input type="checkbox"/> >7.5kg: 4mg/kg every 4 weeks (max of 300mg)	
	<b>Gout Flares</b> <input type="checkbox"/> 150mg sub-q (12 weeks between doses if repeated)	

New Start Therapy    
  Continuation of Therapy    
 Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

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