Local Infusion

MYLOCALINFUSION.COM

ILARIS (CANAKINUMAB) ORDER FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Mobile Number: _____ Patient Weight: _____kg

Allergies: _____

❑ Patient has known difficult venous access. Comments:_____

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: D89.1
  - Muckle-Wells Syndrome (MWS), ICD 10: D89.1
  - Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) in adult and pediatric patients, ICD 10:D89.1
  - Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD) in adult and pediatric patients, ICD 10: D89.1
  - Familial Mediterranean Fever (FMF) in adult and pediatric patients, ICD 10: E85.0

❑ 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

❑ Benadryl 25mg PO

❑ Famotidine 20 mg IV

❑ Cetirizine (Zyrtec) 10 mg PO

❑ Methylprednisolone (Solu-Medrol) 125 mg IVP

❑ Other: _____ Dose: _____ Route: _____

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

FAX NUMBERS:

❑ CT: 203.433.0621
❑ FL: 904.877.9270
❑ MA: 413.296.8482
❑ MD: 240.224.8607
❑ ME: 207.407.7272
❑ NC: 919.984.8698
❑ NH: 603.217.5371
❑ NJ: 201.581.4521
❑ NY: 631.250.6020
❑ OH: 937.871.4594
❑ PA: 610.273.5998
❑ SC: 864.973.6279
❑ VA: 703.202.0499

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MEDICATION

MEDICATION	DOSE / FREQUENCY	ROUTE
Ilaris	**CAPS** ❑ >40kg: 150 mg every 8 weeks ❑ 15-40 kg: 2mg/kg sub-q every 8 weeks. ❑ Other: _____mg	Subq Injection
	TRAPS, HIDS/MKD, and FMF: ❑ Greater than 40kg: 150 mg every 4 weeks. ❑ Greater than 40kg: 300 mg every 4 weeks (lack of clinical response) ❑ <40kg: 2mg/kg every 4 weeks ❑ <40kg: 4mg/kg every 4 weeks (lack of clinical response)	
	Still's Disease (AOSD and SJIA) ❑ >7.5kg: 4mg/kg every 4 weeks (max of 300mg)	
	Gout Flares ❑ 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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