LIFE SPECIALTY SOLUTIONS

ILARIS
(canakinumab)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

DATE OF BIRTH: _____ EMAIL: _____

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
6. Neg TB Test

PRIMARY DIAGNOSIS

Gout:
☐ M1A.9xx0 Chronic gout, unspecified, without tophi
☐ M1A.9xx1 Chronic gout, unspecified, with tophi

Still's Disease:
☐ M08.20 SJIA
☐ M06.1 AOSD

Periodic Fever Syndrome:
☐ M04.1 (FMF, HIDS/MKD, TRAPS, and CAPS)

☐ Other: _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Ilaris

☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Gout
☐ Ilaris 150mg subQ every 12 weeks x _____doses

Still's Disease: SJIA and AOSD
☐ Ilaris 4mg/kg (_____ mg) subQ every 4 weeks. Max of 300mg

PFS: FMF, HIDS/MKD, and TRAPS
☐ Weight >40kg: Ilaris 150mg subQ every 4 weeks
☐ Weight 15kg – 40kg: Ilaris 2mg/kg (_____ mg) subQ every 4 weeks

PFS: CAPS (FCAS and WMS)
☐ Weight >40kg: Ilaris 150mg subQ every 8 weeks
☐ Weight 15kg - 40kg: Ilaris 2mg/kg (_____ mg) subQ every 8 weeks

FIRST DOSE?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted. _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Parkway Pain Care & Rehabilitation PC - Life Specialty Solutions (See lifespecialtysolutions.com for detailed policy)

☐ Other: (Please send other reaction orders if checking this box)

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____

OFFICE CONTACT: _____ FAX: _____

ADDRESS: _____ EMAIL: _____

CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

✖ _____ _____

PROVIDER SIGNATURE DATE