

- Borough Park**
1428 36th Street
Suite 107
Brooklyn, NY 11218
- Crown Heights**
555 Lefferts Avenue
Brooklyn, NY 11225
- Manhattan**
57W 57 Street
Suite 601
New York, NY 10019
- Manhasset**
333 East Shore Road
Suite 201
Manhasset, NY 11030
- Rockville Centre**
165 North Village Avenue
Suite 133
Rockville Center, NY 11570
- Elmsford/ Terrytown**
555 Taxter Road
3rd Floor
Elmsford, NY 10523
- NYC Central Park West**
115 Central Park West
Suite 15
New York, NY 10023
- Woodbury**
75 Froehlich Farm
Woodbury, NY 11797
- Staten Island**
27 New Dorp Lane
Staten Island, NY 10306



- Manhattan**
225 E 70th Street
Suite 1E
New York, NY 10021
- Queens**
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375
- Manhattan**
225 East 70th Street
New York, NY 10021
- Holbrook/Ronkonkoma**
233 Union Ave
Suite 207
Holbrook, NY 11741
- Scarsdale**
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583
- 5 Towns**
141 Washington Avenue
Cedarhurst, NY 11559
- Long Beach**
917 Beech Street
Long Beach, NY 11561
- Riverhead**
1228 E Main Street
Suite A
Riverhead, NY 11901
- Bronx**
226 West 238th Street
Bronx, NY 10463

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 _____