

Westerville
575 Copeland Mill Road
Suite# 2F
Westerville, Ohio 43081



Lancaster
2405 Columbus Street
Suite# 210
Lancaster, Ohio 43130

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)	THERAPY ADMINISTRATION
<input type="checkbox"/> Patient is required to stay for 30 minutes observation period <input type="checkbox"/> Patient is NOT required to stay for observation time <input type="checkbox"/> Other: _____	Canakinumab (Ilaris) For Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis. <input type="checkbox"/> 4mg/kg (with a max of 300mg) for patients with a body weight greater than or equal to 7.5kg subcutaneous every 4 weeks <input type="checkbox"/> Other _____ For Cryopyrin-Associated Periodic Syndromes (CAPS) <input type="checkbox"/> 150mg for patients with body weight greater than 40kg subcutaneous every 8 weeks <input type="checkbox"/> 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg subcutaneous every 8 wks <input type="checkbox"/> Other _____ For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever <i>Body weight less than or equal to 40kg</i> <input type="checkbox"/> 2mg/kg subcutaneous every 4 weeks <input type="checkbox"/> 4mg/kg subcutaneous every 4 weeks - consider if clinical response not adequate. <input type="checkbox"/> Other _____ <i>Body weight greater than 40kg</i> <input type="checkbox"/> 150mg subcutaneous every 4 weeks <input type="checkbox"/> 300mg subcutaneous every 4 weeks - consider if clinical response not adequate. Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed) <input type="checkbox"/> Other _____ <input type="checkbox"/> Total Doses _____ <input type="checkbox"/> Refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X Date _____

Provider _____ Phone _____ Fax _____