

Pensacola
41 Fairpoint Drive
Suite B
Gulf Breeze, FL 32561

Boca Raton
9980 N Central Park Blvd
Suite 202
Boca Raton, FL 33428



Canakinumab (Ilaris)

Provider Order Form

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA	Allergies:	Weight lbs/kg:

REFERRAL STATUS	
☐ New Referral	☐ Referral Renewal
☐ Medication/Order Change	☐ Benefits Verification Only
☐ 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 <i>Body weight less than or equal to 40kg</i> ☐ 2mg/kg subcutaneous every 4 weeks ☐ 4mg/kg subcutaneous every 4 weeks - consider if clinical response not adequate. ☐ Other _____ <i>Body weight greater than 40kg</i> ☐ 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 _____