Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

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

Body weight less than or equal to 40kg

- ☐ 2mg/kg subcutaneous every 4 weeks
- ☐ 4mg/kg subcutaneous every 4 weeks - consider if clinical responsenot 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 _____