

Center City
1528 Walnut Street
Suite 1205
Philadelphia, PA 19102



King Of Prussia
216 Mall Blvd
Suite#1
King Of Prussia, PA, 19046

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 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 _____