Fax: 832-895-4040
Phone: 832-895-5000
E-mail: intake@adaptivinfusion.com

adaptIV infusion

# Ilaris (Canakinumab)

*Provider Order Form rev. 4/10/2022*

## PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### 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

**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

**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.

*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)

### NURSING

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation
☐ TB status & date (list results here & attach clinicals)

_____

### OBSERVATION (PLEASE SELECT BELOW)

☐ Patient is required to stay for 30 minutes observation
☐ Other: _____

* Prior to initiating immunomodulatory therapies, including ILARIS, patients should be evaluated for active and latent tuberculosis infection.

## SPECIAL INSTRUCTIONS

## PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____

*Provider Name (Print)* *Provider Signature* *Date*

**REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK**