INFUSE CARE
PREMIER MEDICAL INFUSIONS

PHYSICIAN ORDER FORM
Fax 1-732-960-3449 · Phone 732-444-8808

Ilaris *canakinumab*

PATIENT INFORMATION

Patient name _____ DOB _____

Mobile number _____ Patient weight _____ kg

Allergies _____

☐ Patient has known difficult venous access. Comments: _____

☐ New start therapy ☐ Continuation of therapy — date of last dose (if applicable): _____

DIAGNOSIS

Provider must specify

☐ Periodic Fever Syndromes: Cryopyrin-Associated Periodic Syndromes (CAPS) in adults and children 4 years and older, including:
- ☐ Familial Cold Auto-inflammatory Syndrome (FCAS), ICD 10: M04.2
- ☐ Muckle-Wells Syndrome (MWS), ICD 10: M04.2
- ☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), adult and pediatric, ICD 10: M04.1
- ☐ Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency (MKD), adult and pediatric, ICD 10: M04.1
- ☐ Familial Mediterranean Fever (FMF), adult and pediatric, ICD 10: M04.1

☐ Active Still's Disease, including Adult-Onset Still's Disease (AOSD), ICD 10: M06.1, and Systemic Juvenile Idiopathic Arthritis (SJIA) in patients 2 years and older, ICD 10: M08.2

☐ Gout flares in adults in whom NSAIDs and colchicine are contraindicated, not tolerated, or inadequate, and in whom repeated courses of corticosteroids are not appropriate, ICD 10: M10. _____

☐ Other: _____

PROVIDER INFORMATION

Provider name (print) _____ Provider NPI _____

Signature _____ Date _____

Contact name _____ Phone _____ Fax _____

Email address _____

PREREQUISITES TO TREATMENT

Ensure the following is complete and attached with the referral

☐ Negative TB ☐ Demographics ☐ Labs and tests supporting diagnosis
☐ Office/progress notes

PRE-MEDICATION

Not typically indicated

☐ Acetaminophen (Tylenol) 500 mg PO ☐ Famotidine 20 mg IV ☐ Methylprednisolone (Solu-Medrol) 125 mg IVP
☐ Diphenhydramine (Benadryl) 25 mg PO ☐ Cetirizine (Zyrtec) 10 mg PO
☐ Other _____ Dose _____ Route _____

MEDICATION ORDER

MEDICATION	CAPS / TRAPS, HIDS/MKD, FMF	STILL'S DISEASE / GOUT	ROUTE
Ilaris	CAPS ☐ >40 kg: 150 mg every 8 weeks ☐ 15–40 kg: 2 mg/kg every 8 weeks ☐ Other: _____ mg TRAPS, HIDS/MKD, and FMF ☐ >40 kg: 150 mg every 4 weeks ☐ >40 kg: 300 mg every 4 weeks (lack of clinical response) ☐ <40 kg: 2 mg/kg every 4 weeks ☐ <40 kg: 4 mg/kg every 4 weeks (lack of clinical response)	Still's Disease (AOSD and SJIA) ☐ >7.5 kg: 4 mg/kg every 4 weeks (max 300 mg) Gout flares ☐ 150 mg (12 weeks between doses if repeated)	Subcutaneous inj.

LABS / SPECIAL INSTRUCTIONS

Order valid for 1 year from date of signature unless otherwise specified here: _____