

Ilaris (canakinumab)

Provider Order Form rev. 7/20/2022

PATIENT INFORMATION

Patient Name:		DOB:		
Patient Phone:		Patient Email:		
NKDA	Allergies:	Weight lbs/kg:	Height:	
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change	Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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ICD-10 CODE

M06.1 Adult onset Still's Disease
M08.20 Systemic Juvenile Arthritis
M04.2 Cryopyrin-associated periodic syndrome (CAPS)
M04.1 Periodic Fever Syndromes

MEDICATION ORDER

Ilaris (canakinumab)

Dose:

2mg/kg SC	150mg SC
3mg/kg SC	300mg SC
4mg/kg SC	

Frequency:

Every 4 weeks

Every 8 weeks

Order Expiration Date (mm/dd/yy): _____

(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print)

Provider Signature

Date

Check here if this is a stat order