immersiv HEALTH

ILARIS® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

- ☐ M04.1 Periodic Fever Syndromes (FMF, HIDS/MKD, and TRAPS)
- ☐ M04.2 CAPS (includes FCAS and MWS)
- ☐ M06.1 Adult-onset Still's Disease
- ☐ M08.2___ Juvenile rheumatoid arthritis with systemic onset
- ☐ M08.9___ Juvenile arthritis
- ☐ M10. ___ Gout flares
- ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most Recent History & Physical ☐ Negative TB screening

MEDICATION ORDER

For GOUT Flare

☐ Ilaris® (canakinumab) 150mg subcutaneous injection

For Still's Disease – SJIA & AOSD 7.5kg or greater

☐ Ilaris® (canakinumab) 4mg/kg subcutaneous injection every 4 weeks (max dose 300mg)

For PFS – CAPS (FCAS & MWS)

☐ **15kg ≤ 40kg:** Ilaris® (canakinumab) 2mg/kg subcutaneous injection every 8 weeks

☐ **15kg ≤ 40kg:** Ilaris® (canakinumab) 3mg/kg subcutaneous injection every 8 weeks

☐ **> 40kg:** Ilaris® (canakinumab) 150mg subcutaneous injection every 8 weeks

For PFS – FMF, HIDS/MKD & TRAPS

☐ **≤ 40kg:** Ilaris® (canakinumab) 2mg/kg subcutaneous injection every 4 weeks

☐ **≤ 40kg:** Ilaris® (canakinumab) 4mg/kg subcutaneous injection every 4 weeks

☐ **> 40kg:** Ilaris® (canakinumab) 150mg subcutaneous injection every 4 weeks

☐ **> 40kg:** Ilaris® (canakinumab) 300mg subcutaneous injection every 4 weeks

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN