ILARIS
(canakinumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Most Recent Labs • Medication List • Neg TB Test

PRIMARY DIAGNOSIS

Gout:
☐ M1A.9xx0 Chronic gout, unspecified, without tophi
☐ M1A.9xx1 Chronic gout, unspecified, with tophi

Still's Disease:
☐ M08.20 SJIA
☐ M06.1 AOSD

Periodic Fever Syndrome :
☐ M04.1 (FMF HIDS/MKD, TRAPS, and CAPS)

☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Ilaris
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Chronic Gout
☐ Ilaris 150mg subQ every 12 weeks x _____doses

Still's Disease: SJIA and AOSD4
☐ Ilaris 4mg/kg (_____ mg) subQ every 4 weeks. Max of 300mg

PFS: FMF, HIDS/MKD, and TRAPS
☐ Weight >40kg: Ilaris 150mg subQ every 4 weeks
☐ Weight 15kg – 40kg: Ilaris 2mg/kg (_____ mg) subQ every 4 weeks

PFS: CAPS (FCAS and WMS)
☐ Weight >40kg: Ilaris 150mg subQ every 4 weeks
☐ Weight 15kg-40kg: Ilaris 2mg/kg (_____ mg) subQ every 4 weeks

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals