Provider Order Form

ILARIS (CANAKINUMAB)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Adult-onset Still's disease M06.1
☐ Systemic Juvenile Idiopathic Arthritis M08.2
☐ Cryopyrin-Associated Periodic Syndromes (CAPS) M04.2
☐ Acute Onset Gout M10 _____
☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever (MF, HIDS/MKD, and TRAPS) M04.1
☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg
☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg
☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg
☐ Cetrizine (Zyrtec) 10 mg PO
☐ Other: _____

THERAPY ADMINISTRATION

Medication Ilaris (Canakinumab), SC	**Dose**
☐ 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 every 4 weeks
☐ For Cryopyrin-Associated Periodic Syndromes (CAPS)	☐ 150mg for patients with body weight greater than 40kg every 8 weeks ☐ 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg 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.
☐ Acute Onset Gout	☐ 150 mg subcutaneously. If re-treatment is required, there should be an interval of at least 12 weeks.

☒ Flush with 0.9% sodium chloride at infusion completion.
☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

SPECIAL INSTRUCTIONS: _____

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX

_____ _____
Provider Signature Date