Ilaris (canakinumab)

Provider Order Form *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☑ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

☐ M04.1 Periodic fever syndromes (e.g. FMF, TRAPS, HIDS/MKDS)
☐ M04.2 Cryopyrin0associated periodic syndromes (CAPS)
☐ M06.1 Adult-onset Still's disease (AOSD)
☐ M08.2 (series): Systematic juvenile idiopathic arthritis (SJIA)
☐ Other: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
☐ Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

☐ Acetaminophen (Tylenol) ☐500mg ☐650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐25mg ☐50mg ☐PO ☐IV
☐ Methylprednisolone (Solu-Medrol) ☐40mg ☐125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: TB results within 1 year
☐ Other: _____

Ilaris (canakinumab) (Select one):

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 subcutaneous every 4 weeks
☐ Other: _____

For Cryopyrin-Associated Periodic Syndromes (CAPS)

☐ 150mg for patients with body weight greater than 40kg subcutaneous every 8 weeks
☐ 2mg/kg for patients with body weight greater than or equal to 15kg and less than or equal to 40kg subcutaneous every 8 wks
☐ Other: _____

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.
☐ Other: _____

Body weight greater than 40kg

☐ 150mg subcutaneous every 4 weeks ☐300mg subcutaneous every 4 weeks - consider if clinical response not adequate.
☐ Other: _____

Gout Flares ☐150 mg subcutaneously 1 dose

☐ **Refills:** ☐ zero ☐6 months ☐12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

Post Treatment Observations: The patient is ☐ not required / ☐ required to stay for 30 minutes following the first administration.

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print) *Provider Signature* *Date*

E: Referrals@americaninfusioncare.com
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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc)**: F: 469.305.2361 P: 972.865.4454**