Canakinumab (Ilaris)

Provider Order Form rev. 10/30/2023

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Cryopyrin-Associated Periodic Syndrome (CAPS): Familial Cold auto-inflammatory syndrome (FCAS):

Hyperimmunoglobulin D Syndrome(HIDS): Familial Mediterranean Fever(FMF):

Mevalonate Kinase Deficiency (MKD): Muckle-Wells Syndrome (MWS):

Adult Onset Still's disease: Systemic Juvenile Idiopathic Arthritis: Gout Flares:

Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS): Other Diagnosis:

THERAPY ADMINISTRATION *(Select one)*

☑ Administer Canakinumab (Ilaris)

For CAPS:

☐ Greater than 40kg: 150mg sub-q every 8 weeks

☐ Less than or equal to 40kg and greater than or equal to 15kg: 2mg/kg _____ mg sub-q every 8 weeks

☐ For children 15-40kg with an inadequate response, the dose can be increased to 3mg/kg _____ mg sub-q every 8 weeks

For TRAPS, HIDS/MKD, and FMF:

☐ Greater than 40kg: 150mg sub-q every 4 weeks ***initially***

☐ Greater than 40kg: 300mg sub-q every 4 weeks ***for lack of clinical response***

☐ Less than or equal to 40kg: 2mg/kg _____ mg sub-q every 4 weeks ***initially***

☐ Less than or equal to 40kg: 4mg/kg _____ mg sub-q every 4 weeks ***for lack of clinical response***

For Still's Disease (AOSD and SJIA):

☐ Greater than or equal to 7.5kg: 4mg/kg _____ mg sub-q every 4 weeks (max of 300mg)

For Gout Flares:

☐ 150mg sub-q. In patients that require re-treatment, there should be an interval of 12 weeks before a new dose.

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Patient has recently had a live vaccine.
- Signs/symptoms of active infection.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with MTX, steroids, Vitamin D analogs, Tazarotene, Tacrolimus, Anthralin, Coal tar biologics. Reason patient can't self-administer. Will not be used in combination with biologic DMARD, Xeljanz, Otezla or TNF inhibitors.

Required Labs: TB results/CRP/ESR, CBC, CMP, >3% body surface area affected

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.