Canakinumab (Ilaris)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

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

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

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

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

Gout:	**Still's Disease:**	**Periodic Fever Syndrome :**
☐ M1A.9xx0 Chronic gout, unspecified, without tophi	☐ M08.20 SJIA	☐ M04.1 (FMF HIDS/MKD, TRAPS, and CAPS)
☐ M1A.9xx1 Chronic gout, unspecified, with tophi	☐ M06.1 AOSD	
☐ Other:		

PRIMARY MEDICATION ORDER

Canakinumab (Ilaris), Subcutaneous injection

- **Patient Eligibility:** Patient must weigh more than 40kg to receive Canakinumab (Ilaris) administration at Arbor Infusion.

☐ Patient is required to stay for 30-minute observation

• Refill for 12 months unless otherwise noted: _____

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

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

☐ **PFS: FMF, HIDS/MKD, and TRAPS:** Weight >40kg: Ilaris 150mg subQ every 4 weeks

☐ **PFS: CAPS (FCAS and WMS):** Weight >40kg: Ilaris 150mg subQ every 8 weeks

PRE-MEDICATION

Note: pre-meds not typically indicated for Ilaris

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV

☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV

☐ Other: _____

Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

SPECIAL INSTRUCTIONS

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

☐ Arbor Infusion Carmel (317) 981-1772