

Canakinumab (Ilaris)

Provider Order Form rev. 8/24/26



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