Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

ILARIS® (canakinumab) Unspecified Plan of Treatment

Rev 4.28.25

PATIENT DEMOGRAPHICS:

Patient Name:					
Patient's Phone:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	M04.1 - FMF, HIDS/MKD, and TRAPS	☐	M08.2___ - Juvenile rheumatoid arthritis w/ systemic onset
☐	M04.2 - CAPS (includes FCAS and MWS)	☐	M08.9___ - Juvenile arthritis, unspecified*
☐	M06.1 - Adult-onset Still's disease	☐	M10.X___ - Gout flares
☐	_____ - Other:		

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	TB screening prior to starting therapy		☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive canakinumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, and/or surgery.

☑ **ILARIS® (canakinumab) as directed via subcutaneous injection**

DOSE/DIAGNOSIS:

Still's Disease (AOSD) & Systemic Juvenile Arthritis (SJIA)

Max dose for AOSD and SJIA is 300mg/dose

☐ **4mg/kg** *(Adults and Peds >/= 2 years and weighing >/=7.5kg)* via subcutaneous injection every 4 weeks

☐ **Other:**_____

Gout Flares

☐ **150mg** via subcutaneously for gout flare

(if retreatment is necessary, do not administer until at least 12 weeks after last dose)

Frequency:

☐ One time dose only

☐ Retreatment permitted x _____doses

Cryopyrin-Associated Periodic Syndromes (CAPS)

Max dose of 8mg/kg/dose (<40kg) for CAPS

Body weight >/= to 15kg but </= to 40kg

☐ **2mg/kg-**via subcutaneous injection every 8 weeks

☐ **3mg/kg-**via subcutaneous injection every 8 weeks

☐ **Other:**_____

Body Weight > than 40kg

Max dose of 600mg (>40kg) for CAPS

☐ **150mg**-via subcutaneous injection every 8 weeks

☐ Other:_____

(TRAPS, HIDS/MKD, and FMF)

(Lowest dose is recommended unless clinical response in not adequate)

Body weight </= to 40kg

☐ **2mg/kg** via subcutaneous injection every 4 weeks

☐ **4mg/kg** via subcutaneous injection every 4 weeks

Body weight > than 40kg

☐ **150mg** via subcutaneous injection every 4 weeks

☐ **300mg** via subcutaneous injection every 4 weeks

☐ **Other:**_____

☐ **SPECIAL ORDERS/DOSING/FREQUENCY:**

_____

_____

Follow each injection with a 30min observation period.

☑ Refills x 12 months unless noted otherwise here:

NURSING ORDERS:

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- ☐ **Patient demographics - address, phone number, SS#, etc.**
- ☐ **Insurance information - copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies - all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis.**

Palmetto Infusion will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility.

Our office will notify you if any further information is required.

We will review financial responsibility with patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.palmettoinfusion.com