ILARIS® (canakinumab)

Horizon Infusions

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to (724) 240-1586

Phone (724) 510-3702

1. PATIENT INFORMATION

Name:	**DOB:**
Phone:	**Other Phone:**
Email:	
Social Security #:	**Allergies:**
Gender: ☐ M ☐ F	**Weight:** ☐ Lbs ☐ Kg

Patient Status: ☐ New to therapy ☐ Continuing therapy ☐ Next due date ***(if applicable)***:

2. INSURANCE INFORMATION (*required*)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		**NPI#:**
License #:	**TIN#:**	**DEA#:**
Address:		
City:		**State** **Zip**
Office Contact:		**Email:**
Office phone:		**Office fax:**

4. DIAGNOSIS INFORMATION (ICD 10 Code *Required*)

☐ Active Stills Disease (_____)
☐ Gout Flares (_____)
☐ Periodic Fever Syndromes (_____)
☐ Other: _____

5. PRESCRIPTION INFORMATION (*requires new order every 12 months*)

For Stills Disease, including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis:
☐ 4mg/kg (max of 300mg) weight ≥ 7.5kg SQ Q 4 weeks

For Cryopyrin-Associated Periodic Syndromes (CAPS):
☐ 150mg weight > 40kg SQ Q 8 weeks
☐ 2mg/kg weight ≥ 15kg and ≤ 40kg SQ Q 8 wks

For Gout flares:
☐ 150mg SQ. In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose can be administered

For Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever:

Weight ≤ 40kg
☐ 2mg/kg SQ Q 4 weeks
☐ 4 mg/kg SQ Q 4 weeks - consider if clinical response not adequate

Weight > 40kg
☐ 150mg SQ Q 4 weeks
☐ 300mg SQ Q 4 weeks - consider if clinical response not adequate

☐ Vital signs per HI protocol
☐ Anaphylaxis & hydration management per HI protocol

6. PRE AND POST MEDICATIONS

PRE-MEDICATIONS

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)
☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV
☐ Prednisone _____ mg PO
☐ Other _____

POST-MEDICATIONS

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg
☐ Prednisone _____ mg PO
☐ Other _____

7. SIGNATURE (required)

_____ _____

PHYSICIAN'S SIGNATURE **DATE**