Horizon Infusions

ILARIS® (canakinumab)

Select location:

- ☐ Akron
- ☐ Anderson
- ☐ Athens
- ☐ Canton
- ☐ Cincinnati (Blue Ash)
- ☐ Cincinnati (West Side)
- ☐ Cleveland (Mayfield)
- ☐ Cleveland (North Olmsted)
- ☐ Columbus (East Broad)
- ☐ Columbus (Hilliard)
- ☐ Columbus (Worthington)
- ☐ Dayton (Beavercreek)
- ☐ Dayton (Englewood)
- ☐ Findlay
- ☐ Liberty
- ☐ Mansfield
- ☐ Mentor
- ☐ Perrysburg
- ☐ Sandusky
- ☐ Springfield
- ☐ Toledo
- ☐ Troy
- ☐ Warren
- ☐ Youngstown
- ☐ Zanesville
- ☐ Crestview Hills (KY)

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

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

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**