PRESCRIPTION ORDER FORM

ILARIS

(canakinumab)

Suite Life
Infusing health and wellness into your life.

Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card •H&P • Patient Demographics • Most Recent Labs • Medication List • Neg TB Test

PRIMARY DIAGNOSIS

Still's Disease:
- ☐ M08.20 SJIA
- ☐ M06.1 AOSD

Periodic Fever Syndrome :
- ☐ M04.1 (FMF HIDS/MKD, TRAPS, and CAPS)

☐ Other: _____

PRE-MEDICATIONS: No Standard premedications typically indicated

- ☐ Diphenhydramine 25mg PO or IVP & 50mg PO or IVP
- ☐ Solu-Medrol 40mg IVP
- ☐ Solu-Medrol 125mg IVP
- ☐ Cetirizine 10mg PO
- ☐ Pepcid 20mg PO or IVP
- ☐ Tylenol 650mg PO
- ☐ Other: _____

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

Still's Disease: SJIA and AOSD4

☐ Ilaris 4mg/kg (fixed dose_____mg subQ every 4 weeks. Max of 300mg.

PFS: FMF, HIDS/MKD, and TRAPS

☐ Weight >40kg: Ilaris 150mg subQ every 4 weeks
☐ Weight 15kg – 40kg: Ilaris 2mg/kg (fixed dose_____mg) subQ every 4 weeks

PFS: CAPS (FCAS and WMS)

☐ Weight >40kg: Ilaris 150mg subQ every 8 weeks
☐ Weight 15kg-40kg: Ilaris 2mg/kg (fixed dose_____mg) subQ every 8 weeks

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See www.suitelifehealth.com for detailed policy)

☐ Other Please: fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____

Provider Signature Date

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