PRESCRIPTION ORDER FORM

# ILARIS
## (canakinumab)

Suite Life
Infusing health and wellness into your life.
215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

## 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 • HBV • Most Recent Labs • HCV • 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: _____

## LAB ORDERS: PLEASE INCLUDE FREQUENCY

☐ CBC w/ diff & ANC: _____ ☐ LFT's at month 2 then every 3 months after ☐ Other: _____

## PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

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

## PRIMARY MEDICATION ORDER

**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 _____