Ilaris Injection

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ M04.2 ☐ M04.1 ☐ M06.1 ☐ M08.2 ____ ☐ M08.9 ____ ☐ M10. ____ ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____ ☐ Frequency: _____

☐ Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

THERAPY ADMINISTRATION

☑ Ilaris Subcutaneous Injection

☐ Still's Disease: SJIA and AOSD
Dose: 4mg/kg (with a max of 300mg) every 4 weeks

☐ PFS: FMF, HIDS/MKS, and TRAPS
- ☐ ≤40kg Dose: 2mg/kg every 4 weeks
  - ☐ Dose can be increased to 4mg/kg every 4 weeks
- ☐ >40kg Dose: 150mg every 4 weeks
  - ☐ Dose can be increased to 300mg every 4 weeks

☐ PFS: CAPS (FCAS and MWS)
- ☐ ≥15kg to 40kg Dose: 2mg/kg every 8 weeks
  - ☐ Dose can be increased to 3mg/kg
- ☐ >40kg Dose: 150mg every 8 weeks

☐ Gout Flare
- ☐ 150mg SubQ x 1 dose

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) Provider Signature Date

☐ ***Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.***