Canakinumab (Ilaris)

Provider Order Form rev. 07/30/2025

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Cryopyrin-Associated Periodic Syndrome (CAPS): Familial Cold auto-inflammatory syndrome (FCAS):

Hyperimmunoglobulin D Syndrome(HIDS): Familial Mediterranean Fever(FMF):

Mevalonate Kinase Deficiency (MKD): Muckle-Wells Syndrome (MWS):

Adult Onset Still's disease: Systemic Juvenile Idiopathic Arthritis: Gout Flares:

Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS): Other Diagnosis:

THERAPY ADMINISTRATION *(Select one)*

☑ Administer Canakinumab (Ilaris)

For CAPS:

☐ Greater than 40kg: 150mg sub-q every 8 weeks

☐ Less than or equal to 40kg and greater than or equal to 15kg: 2mg/kg _____ mg sub-q every 8 weeks

☐ For children 15-40kg with an inadequate response, the dose can be increased to 3mg/kg _____ mg sub-q every 8 weeks

For TRAPS, HIDS/MKD, and FMF:

☐ Greater than 40kg: 150mg sub-q every 4 weeks ***initially***

☐ Greater than 40kg: 300mg sub-q every 4 weeks ***for lack of clinical response***

☐ Less than or equal to 40kg: 2mg/kg _____ mg sub-q every 4 weeks ***initially***

☐ Less than or equal to 40kg: 4mg/kg _____ mg sub-q every 4 weeks ***for lack of clinical response***

For Still's Disease (AOSD and SJIA):

☐ Greater than or equal to 7.5kg: 4mg/kg _____ mg sub-q every 4 weeks (max of 300mg)

For Gout Flares:

☐ 150mg sub-q. In patients that require re-treatment, there should be an interval of 12 weeks before a new dose.

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Patient has recently had a live vaccine.
- Signs/symptoms of active infection.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

ADDITIONAL ORDERS

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with MTX, steroids, Vitamin D analogs, Tazarotene, Tacrolimus, Anthralin, Coal tar biologics. Reason patient can't self-administer. Will not be used in combination with biologic DMARD, Xeljanz, Otezla or TNF inhibitors.

Required Labs: TB results/CRP/ESR, CBC, CMP, >3% body surface area affected

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.