llaris

(canakinumab)



| DATIENT | r DEMOG! | | ^ INE | OPMATI | ON | | | | | | |
|--|--|-----------|---------|--------------------|---------------------------|---------------|--------|--|---|---|--|
| PATIENT DEMOGRAPHIC INFORMATION Patient Name: | | | | | | | Phono | | | | |
| Patient Name: Date of Right | | | | | | Phone: SS: | | | | | |
| | | | | | | | | | | _ | |
| _ | | | | - | | | | | | | |
| | Y DIAGNO | | | | | | | | | | |
| | | | | والخنيين أو والخنا | auttanlai | | | N4001A6 | | | |
| M1A.9xx0 Chronic gout, unspecified, without tophi M1A.9xx1 Chronic gout, unspecified, with tophi | | | | | | | | M06.1 AOSD M04.1 (FMF, HIDS/MKD, TRAPS, and CAPS) | | | |
| M08.20 SJIA | | | | | ιοριπ | | Other: | | | | |
| | | | | | | | | | | | |
| PRESCR | RIPTION | | | | | | | | | | |
| Gout Ilaris 15 | 0mg subQ | every 12 | week? | (S X | _doses | | | | | | |
| | ease: SJIA ng/kg sub(| | | ks. Max o | f 300mg | | | | | | |
| O | , HIDS/MK >40kg: llar 15kg-40kg | is 150mg | gsubC | Qevery 4 | | (S | | | | | |
| _ | S (FCAS a >40kg: llar 15kg-40kg | is 150mg | gsubC | - | | (S | | | | | |
| Has patien Refill x 1 | nt received a 12 months u | | | | | | Yes | No | | | |
| REQUIR | ED DOCU | MENTA | ATION | I | | | | | | | |
| •Insuranc | ce Card | | | | nt Demogra cation List | | | | Most recent labsNegative TB test within past 12 months | | |
| ANCILL | ARY ORDI | ERS | | | | | | | | | |
| ADVERSE | EREACTIO | N & ANA | PHYL | AXIS OR | DERS | | | | | | |
| Administer acute infusion and anaphylaxis medications per Infusion Care Centers' protocol (See aiscaregroup.com for detaile • Epinephrine (weight-based dosing) PRN per protocol | | | | | | | | ced | Other: Please fax other reaction orders if checking this box | | |
| PRE-MED | DICATION | ORDERS | PRO | TOCOL | | | | | | | |
| | nfusion cen | | ocol: N | lo recomr | mended sta | andard p | re-med | s for Ilaris. | | | |
| LAB ORD | ERS-PLE | ASEINC | CLUDE | FREQUE | ENCY | | | | | | |
| Pleas | se list any la | ıbs to be | draw | n by the ir | nfusion clini | ic: | | | | _ | |
| PRESCR | RIBER INF | ORMAI | ΓΙΟΝ | | | | | | | | |
| Prescriber | | | | | | | | | Phone: | | |
| | | | | | | | | | Fax: | | |
| | | | | | | | | | | | |
| Prescriber | · Signatura: | | | | | | | | Date: | | |

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.