ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Canakinumab (Ilaris):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:		**ICD -10 Code:**
	❑ Adult Onset Still's Disease	❑_____
	❑ Periodic fever syndromes	❑_____
	❑ Cryopyrin-Associated Periodic Syndromes (CAPS)	❑_____
	❑ TNF Receptor Associated Periodic Syndrome (TRAPS)	❑_____
	❑ Hyperimmunoglobulin D Syndrome (HIDS)	❑_____
	❑ Mevalonate Kinase Deficiency (MKD)	❑_____
	❑ Familial Mediterranean Fever (FMF)	❑_____
	❑ Other_____	❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs

If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **Reason patient not able to self-administer medication:** _____

Baseline Labs Required:

- Latent TB testing Date: _____/_____/_____ Results: _____

Contact provider if patient develops serious infection; close monitoring by provider is recommended. Follow-up appointment with referring provider scheduled for (date): _____/_____/_____

Treatment Regimens:

- ❑ **Adult Onset Still's Disease:** 4 mg/kg SQ every 4 weeks (MAX 300 mg/dose)
- ❑ **CAPS:** ❑ >40 kg: 150 mg SQ every 8 weeks **OR** ❑ 15 to 40 kg: 2 mg/kg SQ every 8 weeks
- ❑ **MKD, TRAPS, FMF, HIDS:** ❑ >40 kg: 150 mg SQ every 4 weeks **OR** ❑ 2 mg/kg SQ every 4 weeks

☑ **Vital signs:** Check vital signs prior to and at completion of dose.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
CANAKINUMAB (Ilaris)

MultiCare

61-0103-3 (Rev. 9/24)