

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:

- | | |
|-------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Allenmore Infusion Center | <input type="checkbox"/> DHEC Infusion Center |
| <input type="checkbox"/> Auburn Infusion Center | <input type="checkbox"/> North Spokane Infusion Center |
| <input type="checkbox"/> Gig Harbor Infusion Services | <input type="checkbox"/> North Star Lodge Infusion Center |
| <input type="checkbox"/> Puyallup 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:

- 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 _____

ICD -10 Code:

- _____
- _____
- _____
- _____
- _____
- _____
- _____

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)

