

Patient information

Patient name _____

DOB _____

Mobile number _____

Weight _____ kgs lbs

- Diagnosis**
- Cryopyrin-associated periodic syndromes (caps), in adults and children 4 years of age and older, ICD 10: d89.1
 - Familial mediterranean fever (fmf) in adult and pediatric patients, ICD 10: e85.0
 - Active still's disease, including adult-onset still's disease (aosd) m06.1 and systemic juvenile idiopathic arthritis (sjia) in patients 2 years of age and older, ICD 10: m08.2
 - Gout flares in adults in whom non-steroidal anti-inflammatory drugs (nsaids) and colchicine are contraindicated, are not tolerated, or do not provide an adequate response, and in whom repeated courses of corticosteroids are not appropriate
 - Other _____

Allergies NKDA _____

Medication instructions

- Pre-medications**
- N/A
 - Provider prescribed: _____

- | | | |
|-------------------------|---|--|
| Medication order | <p>Dose</p> <ul style="list-style-type: none"> <input type="checkbox"/> Caps: for patients > 40 kg: 150 mg subcutaneously, every 8 weeks. for patients > 15 kg and < 40 kg: 2 mg/kg subcutaneously, every 8 weeks. for pediatric patients 15 kg to 40 kg with an inadequate response, the dose can be increased to 3 mg <input type="checkbox"/> Traps, hids/mkd, and fmf: recommended weight-based dosage is: - for patients > 40 kg: starting dosage is 150 mg subcutaneously every 4 weeks. the dosage can be increased to 300 mg every 4 weeks if the clinical response is not adequate. - for patients < 40 kg: starting dosage is 2 mg/kg subcutaneously every 4 weeks. the dosage can be increased to 4 mg/kg every 4 weeks if the clinical response is not adequate. still's disease (aosd and sjia): recommended weight-based dosage for patients > 7.5 kg is 4 mg/kg (maximum dose of 300 mg), subcutaneously, every 4 week <input type="checkbox"/> Gout flares: recommended dosage is 150 mg subcutaneously. in patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose of ilaris may be administer <input type="checkbox"/> Other _____ | <p>Frequency</p> <p>N/A</p> <p><input type="checkbox"/> Other _____</p> |
|-------------------------|---|--|

- Medication route**
- Subcutaneous injection
 - Other _____

- Lab order**
(Include frequency)
- Please list any labs to be drawn by the infusion clinic:
- N/A
 - _____

Prerequisites Please include the following with your fax submission: Labs and tests supporting diagnosis | Office / progress notes | Demographics | Negative TB test results

Please send to

 Columbia, MD Silver Spring, MD Bowie, MD Frederick, MD**Referring provider information**

Referring provider name _____ NPI _____

Practice name _____

Point of contact Name _____ Email _____ Phone _____

Provider signature _____ Date _____