Ilaris

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

Dose

☐ 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
☐ 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
☐ 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
☐ Other _____

Frequency

N/A
☐ Other _____

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

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SPRINGSIDE INFUSION

Ilaris

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 _____

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