ILARIS (CANAKINUMAB) INJECTION ORDERS

P: 331-236-0610 | **F:** 331-314-8989

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 331-314-8989

Name:		DOB:		Gender: □ Female □ Male	
Address:		City:	State:		ZIP:
Phone:	Email:	Height:	□inches □ cm	Weight:	□lbs. □ kg
Allergies:					
Diagnosis Code ICD-10 (required):		**Diagnosis Description:**			
Patient Status: □ New to Therapy □ Continuing Therapy		Next Treatment Date:			

PHYSICIAN INFORMATION

Prescriber Name:		Phone:		Fax:	
Office Contact:				Email:	
Address:		City:	State:		ZIP:
NPI #:	DEA#			Tax ID:	

INSURANCE INFORMATION (or attach copy of cards)

Primary Insurance:	Policy #:	Group #:
Secondary Insurance:	Policy #:	Group #:

PRESCRIPTION INFORMATION (or attach a copy of the prescription)

Drug	Dosing	Refills
Ilaris (canakinumab)	□ 150mg subQ every 8 weeks □ 150mg subQ every 4 weeks □ 150mg subQ x 1 dose □ 300mg subQ every 4 weeks □ Other: _____ mg subQ every _____ weeks □ Other: _____ mg/kg subQ every _____ weeks □ Other: _____	□ x 1 year □ _____

Other orders: _____

Lab orders: _____ Lab Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwrite "Brand Medically Necessary" and sign to prevent generic substitution.

□ Dispense as written

PRESCRIBER SIGNATURE

By signing this form and utilizing our services, you are authorizing *LIVbetter Infusions.* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Prescriber Signature X: **Date:**

COMPREHENSIVE SUPPORT FOR ILARIS (CANAKINUMAB) THERAPY

PATIENT INFORMATION

Name: DOB:

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

Please answer the following based on patient's diagnosis:

Periodic fever syndromes:

- Physician's Global Assessment (PGA) score: _____
- C-reactive protein lab results: _____

Adult-onset Still's Disease (AOSD) & Systemic Juvenile Idiopathic Arthritis (sJIA):

- Has the patient trialed other biologic therapy indicated for active disease? □Yes □ No
  No If yes, which therapy? _____

Gout:

- Does the patient have a history of at least 3 gout flares in the last 12 months? □ Yes □ No
- Has the patient trialed any of the following? □ NSAIDs □ colchicine □corticosteroids

☐ Include labs and/or test results to support diagnosis

☐ Other medical necessity: _____

REQUIRED PRE-SCREENING

☐ TBscreening testcompletedwithin 12 months - attach results
☐ Positive □ Negative