

Ilaris Order Form

Pre-filled order form for Ilaris (canakinumab) — IL-1 β inhibitor for periodic fever syndromes and Still's disease

REFERRING PROVIDER

PROVIDER NAME	NPI	DEA (IF CONTROLLED)	SPECIALTY
PRACTICE / CLINIC NAME		OFFICE PHONE	OFFICE FAX
OFFICE CONTACT NAME	CONTACT PHONE	CONTACT EMAIL	

PATIENT INFORMATION

PATIENT LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SEX	PATIENT PHONE
		BEST TIME TO CONTACT
ADDRESS		CITY, STATE, ZIP

INSURANCE

PRIMARY INSURANCE	MEMBER ID	GROUP #
SECONDARY INSURANCE (IF ANY)	MEMBER ID	GROUP #

DIAGNOSIS & CLINICAL JUSTIFICATION

PRIMARY DIAGNOSIS	ICD-10 CODE
SECONDARY DIAGNOSIS (IF APPLICABLE)	ICD-10 CODE

Common indications for this medication: Cryopyrin-associated periodic syndromes (CAPS), Adult-onset Still's disease, Systemic juvenile idiopathic arthritis (SJIA), Familial Mediterranean fever, Hyperimmunoglobulin D syndrome / mevalonate kinase deficiency, TNF receptor-associated periodic syndrome (TRAPS)

BRIEF CLINICAL SUMMARY / JUSTIFICATION FOR THERAPY

PRIOR THERAPIES TRIED AND OUTCOME

ILARIS REFERENCE

Generic name: canakinumab
Specialty: Rheumatology
Typical infusion time: About 30 minutes (injection plus brief observation)
Typical schedule: Every 4–8 weeks

MEDICATION ORDER

MEDICATION (DEFAULT: ILARIS)		GENERIC / ALT (CANAKINUMAB)	STRENGTH / FORMULATION
DOSE	FREQUENCY (TYPICAL: EVERY 4&NDASH;8 WEEKS)	DURATION (TYPICAL: ABOUT 30 MINUTES (INJECTION PLUS BRIEF OBSERVATION))	
ROUTE	PRE-MEDICATIONS (IF ANY)	SPECIAL INSTRUCTIONS	
ANTICIPATED START DATE	# OF DOSES AUTHORIZED	SUBSTITUTION ALLOWED (Y/N)	BIOSIMILAR ACCEPTABLE (Y/N)

REQUIRED LABS & MONITORING

Check all labs the prescriber requires Ascribe to verify before each infusion:

- | | | |
|--|--|---|
| ☐ CBC w/ differential | ☐ CMP | ☐ Liver function panel |
| ☐ Hepatitis B/C panel | ☐ TB screen (T-SPOT or QFT) | ☐ Pregnancy test (urine) |
| ☐ Iron studies (ferritin, TSAT) | ☐ Vitamin levels (B12, D, folate) | ☐ Other (specify below) |

OTHER LABS / MONITORING REQUIREMENTS

PRESCRIBER SIGNATURE

By signing below I certify that this order is medically necessary, that I am the prescribing provider for this patient, and that I have reviewed the patient's clinical history relevant to this therapy. Ascribe Infusion Therapy is authorized to coordinate scheduling, prior authorization, and benefits verification on the patient's behalf.

PRESCRIBER SIGNATURE
PRINTED NAME
DATE

Form code: ARB-ORDER-ILARIS · Submit to Ascribe Infusion Therapy by fax to [FAX NUMBER] or via secure portal. Ascribe Infusion will confirm receipt within one business day and begin prior authorization the same day. Questions: [PHONE] · hello@ascribeinfusion.com