

ILARIS (Canakinumab) ORDER FORM

REFERRAL TYPE				
<input type="checkbox"/> New Referral	<input type="checkbox"/> Order Renewal	<input type="checkbox"/> Restart	<input type="checkbox"/> Frequency Change	<input type="checkbox"/> Dosage Change
PREFERRED LOCATION				
<input type="checkbox"/> 2730 University Blvd. West Suite 714 Wheaton, MD 20902	<input type="checkbox"/> 14995 Shady Grove Road Suite 250 Rockville, MD 20850	<input type="checkbox"/> 5454 Wisconsin Avenue Suite 600 Chevy Chase, MD 20815		
<input type="checkbox"/> 18111 Prince Philip Drive Suite 323 Olney, MD 20832	<input type="checkbox"/> 161 Thomas Johnson Drive Suite 250 Frederick, MD 21702	<input type="checkbox"/> 2021 K Street, NW Suite 300 Washington, DC 20006		
	<input type="checkbox"/> 8270 Willow Oaks Corporate Drive Suite 150 Fairfax, VA 22031			
PATIENT INFORMATION				
Name:		DOB:	Email:	
Address:		Weight:	KG	LBS
				Phone:
REFERRING PHYSICIAN INFORMATION				
Name:			NPI:	
Office Contact Name:		Phone:	Fax:	
Address:				
ILARIS ORDER				
OFF-LABEL diagnosis, dose and frequency are subject to medical review and approval.				
Dosing/Frequency:				
<input type="checkbox"/> 4mg/kg every 4 weeks		<input type="checkbox"/> Other: _____ mg/kg every _____ weeks		
<input type="checkbox"/> 2mg/kg every 4 weeks				
Diagnosis:				
<input type="checkbox"/> E85.0—Non-neuropathic hereditary amyloidosis				
<input type="checkbox"/> M04.1—Periodic fever syndromes				
<input type="checkbox"/> M04.2—Cryopyrin-associated periodic syndromes				
<input type="checkbox"/> M06.1—Adult-onset Still's disease				
<input type="checkbox"/> M08.2—Juvenile rheumatoid arthritis with systemic onset				
<input type="checkbox"/> Other Diagnosis:			ICD-10 Code (Required):	
Special Instructions:				
Physicians Signature:			Date: <i>(Order is Valid for One Year)</i>	
REQUIRED DOCUMENTATION				
Please fax the following documents and records:				
<ul style="list-style-type: none"> ● Patient Demographics ● Two most recent office notes (Supporting the DX and treatment ordered) ● Copy of the patient's insurance card(s) – front and back ● Most recent labs that include values for TB screening (PPD, QFT Gold or TSpot) ● Medication History ● For continuation of treatment, include the last infusion note 				
<i>We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.</i>				