Ilaris®

Referring Physician Orders Rev. 07/2025

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height_____ ☐ in ☐ cm

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

*ICD 10 Code Required

For gout flares:

- ☐ Idiopathic gout (M10.00-M10.09), ICD10 _____
- ☐ Lead-induced gout (M10.10-M10.19), ICD10 _____
- ☐ Drug-induced gout (M10.20-M10.29), ICD10 _____
- ☐ Gout d/t renal impairment (M10.30-M10.39), ICD10 _____
- ☐ Other secondary gout (M10.40-M10.49), ICD10 _____
- ☐ Gout, unspecified, M10.49
- ☐ Other: _____, ICD10 _____

For Still's disease:

- ☐ Adult-onset Still's disease [AOSD], M06.1
- ☐ Juvenile rheumatoid arthritis [SJIA] (M08.20-M08.2A), ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Ilaris®(Canakinumab)	☐ For Gout Flares: 150mg SC injection x 1 dose	
	☐ For Still's Disease: _____ mg (4mg/kg; MAXIMUM=300mg) SC injection every 4 weeks x 1 year	

Is patient currently receiving therapy above from another facility?

☐ NO ☐ YES

If yes, Facility Name:_____

Date of last treatment:_____ Date of next treatment:_____

PRE-MEDICATION ORDERS

- ☐ No premeds ordered at this time
- ☐ Acetaminophen 650mg PO ☐ Other:_____
- ☐ Diphenhydramine 25mg PO

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

- ☐ No labs ordered at this time
- ☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____
- ☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ NPI:_____ TIN:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

Clinical Information, select all that apply:

For Gout Flares only:

- ☐ The patient has a history of contraindication, intolerance, or inadequate response to **both** NSAIDS and colchicine.
- ☐ The patient has failed or is not an appropriate candidate for repeated courses of corticosteroids.

Specify reason: _____

For Still's Disease only:

- ☐ The patient has failed initial treatments with conventional therapies for AOSD or SJIA.

LAB AND TEST RESULTS (required)

- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by**:** ☐ Infusion Center ☐ Referring Physician

PRIOR FAILED THERAPIES

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication: _____ Dates of Treatment: _____ Reason for D/C: _____