SPECIALTY INFUSION CENTER
An Access Infusion Care Company

# CANAKINUMAB (Ilaris)

CENTERS AT SIC
An Access Infusion Care Managed Company

| REFERRAL CHECKLIST |
| --- |
| Please ensure the following information is included with your referral: |
| ☐ Patient Demographics and Contact Information |
| ☐ Patient Insurance Information |
| ☐ Completed H&P and Progress Notes Including Medications and Allergies |
| ☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis |
| ☐ CBC w/diff/CMP/CRP/TB testing results/Seum Amyloid A |
| ☐ CAPS Dx: Eye exam report |
| ☐ Completed and Signed Referral |
| Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient.<br>Thank you! |

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834

SPECIALTY INFUSION CENTER
An Access Infusion Care Company

# CANAKINUMAB (Ilaris)

CENTERS AT SIC
An Access Infusion Care Managed Company

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: | Prescriber Name: |
| Address: | NPI: |
| City, State, Zip: | Address: |
| Cell: Email: | City, State, Zip: |
| Ht: Wt: kg Last 4 of SSN: DOB: | Phone: Fax: |
| Allergies: | Contact Person: |

**REFERRAL STATUS** ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last injection:

**DIAGNOSIS**

☐ Dx code/description:

**REQUIRED DOCUMENTATION** ☐ **Signed order** ☐ **Demographics/insurance info** ☐ **H&P/labs/tests/progress notes supporting the Dx**

Prior Therapies:

☐ CAPS DS: Eye exam report

**PRESCRIBING INFORMATION**

**LAB ORDERS**

Frequency: Every Labs: ☐ CMP ☐ CBC w dif ☐ CRP ☐ Sed Rate ☐ Other:

**MEDICATION**

| Medication | Strength | Dose/Directions | | Quantity |
|---|---|---|---|---|
| ☒ **Canakinumab (Ilaris)** | 150mg/mL | **Dose:**<br>☐ 150mg<br>☐ 300mg<br>☐ 2mg/kg<br>☐ 4mg/kg | **Frequency:**<br>☐ every 4 weeks<br>☐ every 8 weeks<br>☐ every weeks | ☒ # vials sufficient for dose<br><br>Refills: |
| | | Inject subcutaneously, max dose 300mg | | |

***If not specified, order will be valid for 1 year from the date of signature.***

**NURSING INSTRUCTIONS/EMERGENCY MEDICATION**

| | |
|---|---|
| RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines<br>Post-Infusion:50ml0.9%NS to flush residual priming volume | PIV:Flush 3-10mL0.9%NS before/after<br>PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/5mLHeparin 100u/mL(Port)final |

Administer the following medications as needed for infusion-related reactions per company protocol:
**Adults>40kg:**Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60 min, may repeat×1 for hypotension.
**Pediatrics/Adults<40kg:**Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60min, may repeat×1 for hypotension.
**Oxygen(AIC/AIS only):**1-6L/min via NC/face mask; titrate to maintain $SpO_2$95-100%.

**Prescriber Signature X:** _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

©Specialty Infusion Center
Print, complete, and fax completed form to (855) 857-3834