



A Carelon Company

ILARIS (CANAKINUMAB) INJECTION ORDERS

P: 877-365-5566 | F: 855-889-2946

PATIENT INFORMATION Fax completed form, insurance information, and clinical documentation to 855-889-2946

Name:		DOB:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Address:		City:	State:	ZIP:
Phone:	Email:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg
Allergies:				

Diagnosis Code ICD-10 (required):	Diagnosis Description:
Patient Status: <input type="checkbox"/> New to Therapy <input type="checkbox"/> 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)	<input type="checkbox"/> 150mg subQ every 8 weeks	<input type="checkbox"/> x 1 year <input type="checkbox"/> _____
	<input type="checkbox"/> 150mg subQ every 4 weeks	
	<input type="checkbox"/> 150mg subQ x 1 dose	
	<input type="checkbox"/> 300mg subQ every 4 weeks	
	<input type="checkbox"/> Other: _____ mg subQ every _____ weeks	
	<input type="checkbox"/> Other: _____ mg/kg subQ every _____ weeks	
	<input type="checkbox"/> Other: _____	

Other orders: _____

Lab orders: _____ Lab Frequency: _____

As required by your state, Prescriber to check "Dispense as written" or handwritten "Brand Medically Necessary" and sign to prevent generic substitution.	<input type="checkbox"/> Dispense as written
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PRESCRIBER SIGNATURE By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. 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: _____

PATIENT INFORMATION

Name:

DOB:

REQUIRED DOCUMENTATION FOR REFERRAL CROSSING & 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

- TB screening test completed within 12 months - attach results
 - Positive Negative