

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Most Recent Labs
- Medication List
- Neg TB Test

PRIMARY DIAGNOSIS

Still's Disease:
 M08.20 SJIA
 M06.1 AOSD
 Other: _____

Periodic Fever Syndrome :
 M04.1 (FMF HIDS/MKD, TRAPS, and CAPS)

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Ilaris
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Still's Disease: SJIA and AOSD4
 Ilaris 4mg/kg (fixed dose _____ mg subQ every 4 weeks. Max of 300mg.

PFS: FMF, HIDS/MKD, and TRAPS
 Weight >40kg: Ilaris 150mg subQ every 4 weeks
 Weight 15kg – 40kg: Ilaris 2mg/kg (fixed dose _____ mg) subQ every 4 weeks

PFS: CAPS (FCAS and WMS)
 Weight >40kg: Ilaris 150mg subQ every 8 weeks
 Weight 15kg-40kg: Ilaris 2mg/kg (fixed dose _____ mg) subQ every 8 weeks

First Dose: Y N Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____