



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

ILARIS ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

M10.X ____ Gout Flare

M06.1 ____ Adult -onset Still's disease (AOSD)

Other _____

DOSAGE ORDERS:

150 mg SQ Every 12 weeks as needed (gout)

4mg/kg SQ (with a maximum of 300mg) Every 4 weeks (AOSD)

Other _____

PREMEDICATION ORDERS:

Acetaminophen: 1000mg PO 500mg PO 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Methylpredisolone: 62.5mg IVP 125mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- TB Hep B Other: _____