

Nevada Infusion 5401 Longley Lane, Suite 34, Reno, NV 89511

PH: 775-453-0667 | Fax: 775-470-8478

Ilaris Order Form

Phone:	Patient Name:				DOB:		
Sex:	Phone:		Address:				
Sex:	City:	State:	Zip:	Email:			
Adult onset Still's Disease ICD-10: M06.1 Cryopyrin-associated periodic syndrome (CAPS) ICD-10: Systemic Juvenile Arthritis ICD-10: M08.20 M04.2 ICD-10: I							
Systemic Juvenile Arthritis ICD-10: M08.20 M04.2 Other:	DIAGNOSIS:						
Periodic Fever Syndromes ICD-10: M04.1	☐ Adult onset Still's Disease ICD-10: M06.1			☐ Cryop	pyrin-associated periodic syndrome (CAPS) ICD-10:		
ORDER FOR ILARIS (CANAKINUMAB): Dosing:	Systemic Juvenile Arthritis ICD-10: M08.20			M04.2	M04.2		
Dosing:	Periodic Fever Syndromes ICD-10: M04.1		☐ Other	Other:ICD-10:			
2mg/kg Subcutaneously	ORDER FOR I	ILARIS (CANAKINUMAB)):				
3mg/kg Subcutaneously	Dosing:			Frequency:			
dmg/kg Subcutaneously	☐ 2mg/kg Subcutaneously			☐ Every 4 w	☐ Every 4 weeks		
150mg Subcutaneously 300mg Subcutaneously 300mg Subcutaneously Other: PRE-MEDICATIONS: Acetaminophen 650mg PO Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO Hydrocortisone 100mg IV or Methylprednisolone 125mg IV Additional Pre-Medications: MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION: Nevada Infusion Hypersensitivity Reaction Order Set Other: ACCESS: Peripheral IV, Port, Midline, or PICC line FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml NURSING: Per Nevada Infusion Fax results to: PROVIDER INFORMATION: Physician Name: NPI: Physician Signature: Date: Date: Date: Date: PROVIDER INFORMATION: Date: Date: PROVIDER INFORMATION: Date: Date: PROVIDER INFORMATION: Physician Signature: Date: Date: PROVIDER INFORMATION: Date: Date: PROVIDER INFORMATION: Physician Signature: PROVIDER INFORMATION: Physician Signature: PROVIDER INFORMATION: PROVIDER INFORMATION: Physician Signature: Date: PROVIDER INFORMATION: Physician Signature: PROVIDER INFORMATION: PRO	,				I '		
300mg Subcutaneously			\square Other:				
PRE-MEDICATIONS:	_	· ·					
PRE-MEDICATIONS: Acetaminophen 650mg PO Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO Hydrocortisone 100mg IV or Methylprednisolone 125mg IV Additional Pre-Medications: MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION: Nevada Infusion Hypersensitivity Reaction Order Set Other: ACCESS: Peripheral IV, Port, Midline, or PICC line FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml NURSING: Per Nevada Infusion LABS ORDERS: Fax results to: PROVIDER INFORMATION: Physician Name: Physician Signature: Date: Date:	_	·					
Acetaminophen 650mg PO Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO Hydrocortisone 100mg IV or Methylprednisolone 125mg IV Additional Pre-Medications: MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION: Nevada Infusion Hypersensitivity Reaction Order Set Other:	☐ Other: _						
✓ Nevada Infusion Hypersensitivity Reaction Order Set ☐ Other: ACCESS: Peripheral IV, Port, Midline, or PICC line FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml NURSING: Per Nevada Infusion LABS ORDERS: Fax results to: PROVIDER INFORMATION: Physician Name: NPI: Physician Signature: Date: Date: Date:	(((☐ Acetaminophen 65☐ Diphenhydramine 2☐ Hydrocortisone 100	25mg PO or IV or Zyr Omg IV or Methylpred	dnisolone 125mg			
Other:	MAY ADMI	NISTER IF NEEDED FOF	R ALLERGIC REACTION	N:			
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml NURSING: Per Nevada Infusion LABS ORDERS: Fax results to: PROVIDER INFORMATION: Physician Name: NPI: Physician Signature: Date:			-				
NURSING: Per Nevada Infusion LABS ORDERS: Fax results to: PROVIDER INFORMATION: Physician Name: NPI: Physician Signature: Date:		•					
LABS ORDERS: Fax results to: PROVIDER INFORMATION: Physician Name: NPI: Physician Signature: Date:			fusion OR Heparin 5r	nl for port – 100 ເ	units/ml		
PROVIDER INFORMATION: Physician Name: NPI: Physician Signature: Date:	NURSING: F	Per Nevada Infusion					
Physician Name: NPI: Physician Signature: Date:	LABS ORDERS:				ults to:		
Physician Name: NPI: Physician Signature: Date:	PROVIDER I	NFORMATION:					
Physician Signature: Date:				ſ	NPI:		
					Date:		

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

^{**}Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **



Nevada Infusion 5401 Longley Lane, Suite 34, Reno, NV 89511

PH: 775-453-0667 | Fax: 775-470-8478

Patient Name:	_ DOB:
Please Include Required Documentation for Expedited Order Processing & Insu	ırance Approval:
\square Signed provider orders (page 1)	
\square Patient demographic and insurance information	
☐ Patient's current medication list	
\square Supporting recent clinical notes and H&P (to support primary diagnosis)	
\square Supporting documentation to include past tried and/or failed therapies	
\square Include labs and/or test results to support diagnosis	
\square Other medical necessity documentation (please include):	