

LAWRENCE COUNTY
Memorial  Hospital
DEACONESS ILLINOIS PARTNER

PATIENT INFORMATION		
Name:	DOB:	
Allergies:	Date of Referral:	
REFERRAL STATUS		
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal		
DIAGNOSIS AND ICDE 10 CODE		
<input type="checkbox"/> Adult-Onset Still's Disease (AOSD) <input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA) <input type="checkbox"/> Cryopyrin-Associated Periodic Syndromes (CAPS) <input type="checkbox"/> Hyperimmunoglobulin D Syndrom (HIDS) <input type="checkbox"/> Mevalonate Kinase Deficiency (MKD) <input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis <input type="checkbox"/> Other:	ICD 10 Code: M06.1 ICD 10 Code: M08.20 ICD 10 Code: M04.2 ICD 10 Code: M04.1 ICD 10 Code: M04.1 ICD 10 Code: M06.9 ICD 10 Code:	<input type="checkbox"/> Familial Mediterranean Fever (FMF) ICD 10 Code: M04.1 <input type="checkbox"/> Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) ICD 10 Code: M04.1 <input type="checkbox"/> Gout Flare ICD 10 Code: M10.9
REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)		
<input type="checkbox"/> The signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Prior authorization with reference number *Pt may be required to submit a pregnancy test prior to treatment	<input type="checkbox"/> Clinical/Progress notes (must be within 1 year) <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> TB test results	
List tried and failed therapies including duration of treatment:		
1) _____ 2) _____		
MEDICATION ORDERS		
Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ Pt WT required for weight-based orders		
HIDS MDK FMP TRAPS	<input type="checkbox"/> ≤40kg <input type="checkbox"/> >40kg	<input type="checkbox"/> J0638 Ilaris 2mg/kg SubQ every 4 weeks <input type="checkbox"/> Other: _____ <input type="checkbox"/> J0638 Ilaris 150mg SubQ every 4 weeks <input type="checkbox"/> Other: _____
CAPS	<input type="checkbox"/> ≥ 15kg to <40 kg <input type="checkbox"/> >40kg	<input type="checkbox"/> J0638 Ilaris 2mg/kg SubQ every 8 weeks <input type="checkbox"/> Other: _____ <input type="checkbox"/> J0638 Ilaris 150mg SubQ every 8 weeks
AOSA SJIA	≥7.5kg	<input type="checkbox"/> J0638 Ilaris 4mg/kg SubQ (Max of 400mg) every 4 weeks
Gout Flare		<input type="checkbox"/> J0638 Ilaris 150mg SubQ every 12 weeks x _____ doses In patients that require re-treatment, there should be an interval of at least 12 weeks before a new dose of Ilaris may be administered.
Duration: <input type="checkbox"/> x6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> x _____ doses		
LAB ORDERS		
<input type="checkbox"/> CBC <input type="checkbox"/> prior to each treatment or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> CMP <input type="checkbox"/> prior to each treatment or <input type="checkbox"/> Frequency: _____ <input type="checkbox"/> Other: _____		
PRESCRIBER INFORMATION		
Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515

FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS –ILARIS (CANAKINUMAB)