## Ilaris® (canakinumab) Referral Form





PATIENT INFORMATION	New Referra	l Updated Referral	Referral Renewal	
DOB: Patient Name:		Patient Phone:		
Patient Address:		Patient Email:		
NKDA Allergies:		Weight (lbs/kg):	Height:	
ICD-10 Code (required): ICD-10 Description:	Last Treatment Date:	Last 4 Digits SSN:		
PROVIDER INFORMATION				
Referral Coordinator Name:	Referral Coordinator Email	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:			
Referring Practice Name:	Phone:	Fax:		
Practice Address:	City:	State: Zip	Code:	
Physician Preferred Method of Contact: Email:	Fax:	Phone:		
ILARIS ADI	MINISTRATION 🗹	Infusion to be administere	ed per Vivo protocols.	
Cryopyrin-Associated Periodic Syndromes (CAPS)  Greater than 40 kg: 150 mg subcutaneous ever	ry 8 weeks			
	rv 8 weeks			
Greater than or equal to 15 kg and less than or	equal to 40 ka: 2 mg/kg subcutaneou	ıs every 8 weeks		
Tumor Necrosis Factor Receptor Associated Periodic Sy Mediterranean Fever		•	se Deficiency, Familia	
Body weight less than or equal to 40 kg				
2 mg/kg subcutaneous every 4 weeks	D.C.	OURED DOCUMENTA	TION	
4 mg/kg subcutaneous every 4 weeks	KE	REQUIRED DOCUMENTATION		
Body weight greater than 40 kg		Patient Demographics		
150 mg subcutaneous every 4 weeks		Insurance card/Inform	ation	
300 mg subcutaneous every 4 weeks		Progress Notes supporting DX		
		Medication List and H&P		
Gout Flares				
150 mg subcutaneously x 1 dose		TB results within 1 yea	r	
Provider Name (Print) Pro	vider Signature	i	Date	

## Email Referrals To: referrals@vivoinfusion.com OR Fax Below Have a Question? Call (720) 902-4111

 Colorado: 303-418-4679
 Michigan: 833-957-2188
 New York: 800-540-1852
 Texas: 469-340-0044

 Connecticut: 203-724-4838
 Minnesota: 763-290-0903
 Ohio: 216-400-0674
 Virginia: 804-500-5941

 Florida: 904-930-4211
 Nevada: 702-489-5744
 Oklahoma: 918-770-4421
 Wisconsin: 414-600-5383

Massachusetts: 781-202-1629 New Jersey: 609-955-3711 Pennsylvania: 215-399-9244