Ilaris® (canakinumab) Referral Form

Preferred Clinic (select one): _____

VIVO infusion®

PATIENT INFORMATION

☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Injection Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: 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 ADMINISTRATION

☑ Infusion to be administered per Vivo protocols.

Stills Disease including Adult Onset Stills Disease and Systemic Juvenile Idiopathic Arthritis

☐ 4 mg/kg (with a max of 300mg) for patients with a body weight greater than or equal to 7.5 kg subcutaneous every 4 weeks

Cryopyrin-Associated Periodic Syndromes (CAPS)

☐ *Greater than 40 kg:* 150 mg subcutaneous every 8 weeks

☐ *Greater than or equal to 15 kg and less than or equal to 40 kg:* 2 mg/kg subcutaneous every 8 weeks

Tumor Necrosis Factor Receptor Associated Periodic Syndrome, Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency, Familial Mediterranean Fever

Body weight less than or equal to 40 kg

☐ 2 mg/kg subcutaneous every 4 weeks

☐ 4 mg/kg subcutaneous every 4 weeks

Body weight greater than 40 kg

☐ 150 mg subcutaneous every 4 weeks

☐ 300 mg subcutaneous every 4 weeks

Gout Flares

☐ 150 mg subcutaneously x 1 dose

REQUIRED DOCUMENTATION

☐ **Patient Demographics**

☐ **Insurance card/Information**

☐ **Progress Notes supporting DX**

☐ **Medication List and H&P**

☐ **TB results within 1 year**

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

Provider Name (Print) **Provider Signature** **Date**

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

Colorado: 303-418-4679	Massachusetts: 781-202-1629	New Jersey: 609-955-3711	Oklahoma: 918-770-4421	Virginia: 804-500-5941
Connecticut: 203-724-4838	Michigan: 833-957-2188	New York: 800-540-1852	Pennsylvania: 215-399-9244	Wisconsin: 414-600-5383
Florida: 904-930-4211	Minnesota: 763-290-0903	Ohio: 216-400-0674	Texas: 469-340-0044	

Referral is valid for one year unless otherwise noted.

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