Ilaris Injection Order

LivWell INFUSIONS

Fax 888 511-7654 Phone 888 864-7341

Patient Name: _____ **DOB:** _____

Patient Phone: _____ **SEX:** M ◯ F ◯

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis:

- ◯ M04.2 Cryopyrin-Associated Periodic Syndromes(CAPS) Includes FCS and MWS
- ◯ M04.1 Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS) Hyperimmunoglobulin D Syndrome(HIDS)/ Mevalonate Kinase Deficiency (MKD) Familial Mediterranean Fever(FMF)
- ◯ M06.1 Adult-Onset Still's Disease (AOSD)
- ◯ M08.2 Systemic Juvenile Idiopathic Arthritis (SJIA)

ICD 10: _____

Patients weight: _____

Lab Date: _____

Allergies: _____

ALSO INCLUDE...

- ◯ Clinical/ Progress Notes
- ◯ Demographics Sheet
- ◯ Current Medications
- ◯ Labs

ILARIS ORDER

Ilaris Dose: See Prescribing Dosing Chart

Patients Weight: _____ **Dose:** _____ **Frequency:** _____

Date Last Injection: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ **Phone:** _____

Practice Address: _____

Office Contact: _____ **Fax:** _____

NPI/ TIN: _____

Referring Physician's Signature _____ **Date:** _____