TwelveStone Health Partners

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

ILARIS ORDER FORM

Date: ______________________ ICD-10 Code: ______________________

Patient Name: ______________________ Allergies: ______________________

Date of Birth: ______________________ Weight: ________ lbs OR ________ kg

Therapy Status

☐ New Start

☐ Continuing Therapy:
Last Dose: ______________________

PROVIDER INFORMATION

Ordering Provider: ______________________ Provider Fax: ______________________

Provider NPI: ______________________ Provider Address: ______________________

Provider Phone: ______________________

MEDICATION ORDER

Ilaris	**Still's Disease** ☐ Ilaris 4mg/kg (maximum dose of 300mg) SQ every 4 weeks **Gout Flares** ☐ Ilaris 150mg SQ once *Minimum of 12 week interval for subsequent dosing r/t gout*	Refills x one year from date of signature unless indicated below. ☐ ________ Refills	***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:*** ✓ TB Quant Gold within the past 12 months

PRE-MEDICATIONS

Oral

- ☐ Acetaminophen: ______325mg ______500mg ______650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ______25mg ______50mg
- ☐ Famotidine: ______20mg ______40mg
- ☐ Ibuprofen: ______ 200mg ______400mg______600mg
- ☐ Ondansetron: ______4mg ______ 8mg
- ☐ Other: ______________________

IV

- ☐ Dexamethasone: ______4mg ______8mg
- ☐ Diphenhydramine: ______25mg______50mg
- ☐ Famotidine: ______20mg______40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ______4mg ______8mg
- ☐ Other: ______________________

LAB ORDERS (please indicate any labs to be drawn and frequency)

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

Dispense as Written:	Substitution Allowed:
______________________ Prescriber Name ________ Date	______________________ Prescriber Name ________ Date

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