Ascension Rx

Canakinumab (Ilaris & Biosimilars) Infusion Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ CBC with Differential
    - ☑ TB screening (QuantiFERON or alternative)
    - ☑ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
    - ☑ Hepatic Function Panel
    - ☑ HIV
  - ☐ Maintenance (every _____)
    - ☐ CBC with Differential
    - ☐ Hepatic Function Panel
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Live vaccines should not be given concurrently

Nursing Orders

- ☑ Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

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Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg IV once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

Medication Orders (select only one)

CAPS Dosing:

- ☐ Canakinumab 150 mg SQ once every 8 weeks (> 40 kg)
- ☐ Canakinumab 2 mg/kg (_____ mg) SQ once every 8 weeks (≥ 15 kg and ≤ 40 kg)
- ☐ Canakinumab _____ mg/kg (_____ mg) SQ once every ____ weeks (> 40 kg)
- ☐ Canakinumab _____ mg/kg (_____ mg) SQ once every ____ weeks (≤ 40 kg)

TRAPS, HIDS/MKD, and FMF Dosing:

- ☐ Canakinumab 150 mg SQ once every 4 weeks (> 40 kg)
- ☐ Canakinumab 2 mg/kg (_____ mg) SQ once every 4 weeks (≤ 40 kg)

If clinical response is not adequate:

- ☐ Canakinumab 300 mg SQ once every 4 weeks (> 40 kg)
- ☐ Canakinumab 4 mg/kg (_____ mg) SQ once every 4 weeks (≤ 40 kg)

Still's disease (AOSD and SJIA) Dosing:

- ☐ Canakinumab 4 mg/kg (_____ mg) SQ once every 4 weeks (max dose 300 mg)
- ☐ Canakinumab 4 mg/kg (_____ mg) SQ once every ____ weeks (max dose 300 mg)

Gout Flares Dosing:

- ☐ Canakinumab 150 mg SQ once

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____
Rounded Dose: _____ mg

Rationale for Substitution:

- ☐ Payer-mandated substitution
- ☐ Financial stewardship
- ☐ Patient access / hardship

Pharmacy may adjust dose ±10% of ordered dose per approved protocol. Pharmacy may substitute a biosimilar based on insurance coverage.

9/18/2026

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Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Using a sterile 1-mL syringe and 18-gauge x 2” needle, carefully withdraw the required volume depending on the dose to be administered and subcutaneously inject using a 27-gauge x 0.5” needle.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated