

**STANDARD REMICADE PLAN OF TREATMENT
FOR RHEUMATOID DIAGNOSES
For Palmetto Infusion Services Patients**

(Re) Certification Period From _____ to _____

NOTE: Patient is *ineligible* to receive Remicade if receiving antibiotic for active infectious process due to the possibility of developing a superinfection related to its effect on the immune status, or has a suspected infectious process.

Patient's Name _____ HT: _____ WT _____ Allergies: _____

DIAGNOSIS: 714.0 or 714.2 For Rheumatoid Arthritis (Please check one)
 696.0 Psoriatic Arthropathy* 720.0 Ankylosing Spondylitis * Other _____

Physician Office to Complete:

1. Has your patient had failure, intolerance, or contraindication to conventional therapy?
 Yes No
2. If yes, please specify, treatment/medication tried and outcomes: _____

Premedicate None **OR**

30 minutes prior to infusion with 650 mg Acetaminophen PO and one of the following *oral* antihistamines:

Diphenhydramine 50 mg Allegra 60 mg Allegra 180 mg Zyrtec 10 mg Claritin 10 mg

OR Premedicate with other _____

Obtain weight each visit. Vital signs every 30 minutes beginning with start of infusion and 30 minutes after completion, for first 3 treatments, then may d/c when infusion is complete. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.

Normal Saline Flush 5 ml before and after infusion followed by Heparin Lock 1 – 5 ml 100 unit/ml as needed per line type Pump, tubings, and supplies needed to complete prescribed therapy.

DOSE: _____ Remicade 3 mg/kg per 250 ml normal saline intravenous to infuse over 2 hours **OR**
 _____ Other Dose: _____ mg/kg per 250 - 500 ml normal

FREQUENCY: _____ Orders to be completed at ___0, ___2, ___6 weeks, and ___every 8 weeks thereafter
 _____ Orders every 8 weeks (maintenance).
 _____ Special Orders:

Lab work: On initial visit- Draw Australian Hep B surface antigen. Other: _____

OTHER:

Pharmacist to perform clinical drug monitoring.

Physician's Signature: _____ / _____ Date: _____

(Dispense as written)

(Substitution permitted)

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to

Patient should have a negative PPD within 6 months, or documented absence of active TB.

Does the patient have a history of (circle each): TB SOB Cough Night Sweats Fever Weight Loss None

Has the patient had recent exposure to TB or been out of the country in the past month? ___Yes ___ No

Does the patient have a family history of TB? ___ Yes ___ No

Has the patient had a PPD test? ___ Yes ___ No Date _____ Results _____

(greater than or equal to 5 mm induration is + for this patient population)

Chest X-Ray ___ Yes ___ No Results: _____ Previous Treatment for TB? ___ Yes ___ No