

MRN: \_\_\_\_\_

**STANDARD REMICADE PLAN OF TREATMENT  
FOR DERMATOLOGY PATIENTS**

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:**  696.0 Psoriatic Arthritis/Arthropathy  696.1 Psoriasis- Chronic Severe

*Please send documentation regarding severity or body surface area affected*

**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 Standard 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 5 mg/kg per 250 ml normal saline intravenous to infuse over 2 hours **OR**

\_\_\_\_\_ Other Dose: \_\_\_\_\_mg/kg per 250 - 500 ml normal saline

**FREQUENCY:** \_\_\_\_\_ Orders to be completed at \_\_\_\_\_ 0, \_\_\_\_\_ 2, & \_\_\_\_\_ 6 weeks.

\_\_\_\_\_ 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