MRN:____________________

STANDARD REMICADE PLAN OF TREATMENT
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: ☐ *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 units/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 ___ NoResults: _______________ Previous Treatment for TB? ___Yes ___ No