



MRN: _____
DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

STANDARD REMICADE® (infliximab) PLAN OF TREATMENT

(Re) Certification Period From _____ to _____

NOTE: Patient may be ineligible to receive infliximab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, new-onset or deterioration neurological changes, and/or surgery.

- 1. Patient Name:** _____ Height (inches): _____ Weight (lbs): _____
2. Allergies: _____
3. DIAGNOSIS: ICD-10 Code: _____ Diagnosis Description: _____

4. Pre-medications: None **OR** Administered 30 minutes prior to infusion as selected:

***Product information suggests premedication of antihistamines, acetaminophen, and/or corticosteroids.**

<p>a) Acetaminophen: <input type="checkbox"/> 650mgs PO <input type="checkbox"/> 500mgs PO <input type="checkbox"/> 325mgs PO</p>	<p>b) Diphenhydramine: <input type="checkbox"/> 25 mgs PO, <input type="checkbox"/> 50mgs PO, <input type="checkbox"/> 25 mgs IVP, <input type="checkbox"/> 50mgs IVP or c) Alternate oral antihistamine to diphenhydramine: <input type="checkbox"/> Cetirizine 10 mg, <input type="checkbox"/> Loratadine 10 mg, Fexofenadine <input type="checkbox"/> 60mgs or <input type="checkbox"/> 180mgs d) Other: Methylprednisolone <input type="checkbox"/> 40mgs IVP <input type="checkbox"/> 125mgs IVP or other _____mgs IVP Famotidine: <input type="checkbox"/> 20mgs PO, <input type="checkbox"/> 40mgs PO, <input type="checkbox"/> 20mgs IVP, <input type="checkbox"/> 40mgs IVP</p>
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e) Pre-medicate with other: _____

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Orders: Obtain weight each visit. **Vital signs at baseline, every 30 minutes beginning with start of infusion, at completion, 30 minutes after completion for the first 3 treatments, and then may discharge when infusion is complete.** Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Pump, tubing, 0.22 micron filter, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. **If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.**

5. Dose: _____ Remicade® (infliximab) 3 mg/kg per 250 ml Sodium Chloride 0.9% IV to infuse over at least 2 hours **OR**
_____ Other Dose: _____ mg or _____ mg/kg per 250 - 500 ml Sodium Chloride 0.9% IV

6. Frequency: _____ Induction orders to be completed at 0 week, 2 week, and 6 weeks, and then every 8 weeks thereafter
_____ Orders every 8 weeks (maintenance).
_____ Special Orders: _____

Lab orders with infusions: _____

7. Physician's Signature: _____ / _____ Date: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders
Infusion order forms available at www.palmettoinfusion.com



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Standard Guidelines for Prescribing Remicade® (infliximab)

(Required documentation with all initial referrals)

Patient Name: _____

Referral Date: _____

___ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-8)
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Remicade® as specified of _____ weeks. Last known biological therapy: _____ and last date received: _____. (Include copy of last Remicade® infusion record if available and currently on therapy)

___ Other as requested: _____

Pre-Screening: (TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months.)

___ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

___ **Required Hepatitis screening to include: Hepatitis B Surface Antigen results.**

**Product information suggests that patients who have stopped treatment for an extended period are at higher risk for hypersensitivity reactions. MD should evaluate premedication and consider antibody testing prior to restart of therapy.*

** Warnings/Precautions: **Serious Infections:** Patient should not have an active ongoing infection, signs or symptoms of malignancy, or invasive fungal infection. Do not initiate Remicade® (infliximab) therapy in patients with **moderate to severe Congestive Heart Failure. Remicade® (infliximab) at doses of >5 mg/kg should not be administer to patients with moderate to severe heart failure.** Patient with mild CHF currently receiving Remicade® (infliximab) should be closely monitored. Therapy should be discontinued in patients who develop new or worsening symptoms of heart failure. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently with Remicade®. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.