

**STANDARD REMICADE PLAN OF TREATMENT**

(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 super-infection related to its effect on the immune status), or if he/she has a suspected infection.

**PATIENT'S NAME** \_\_\_\_\_ **HT:** \_\_\_\_\_ **WT:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_

**Diagnosis:**

\_\_\_\_\_

**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  Fexofenadine 60 mg  Fexofenadine 180 mg  Cetirizine 10 mg  Loratadine 10 mg

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 discharge 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 3 mg/kg per 250 ml normal saline intravenous to infuse over 2 hours *OR*

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

**Frequency:**  Orders to be completed at  0 week  2 weeks &  6 weeks, *then:*

Orders every 8 weeks (maintenance)

Special Orders: \_\_\_\_\_

**Lab work:**

\_\_\_\_\_

**Other:** Pharmacist to perform clinical drug monitoring.

(no stamped signatures please)

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Dispense as written) (Substitution permitted)

Print Physician Name: \_\_\_\_\_

**PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920**

**Patient should have a negative PPD within 6 months, documented absence of active TB, as well as documented Hep B surface antigen.**

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 Chest X-Ray:  Yes  No Results: \_\_\_\_\_

Has the patient had a PPD test?  Yes  No Date \_\_\_\_\_ Results \_\_\_\_\_ **Palmetto must have copy on file**

Any previous treatment for TB?  Yes  No

Has patient received **TNF therapy in past 6 months?**  Yes  No Therapy: \_\_\_\_\_ Last date Received: \_\_\_\_\_

Hep B surface antigen drawn:  Yes  No Please fax results with referral along with PPD results