

Phone: 800-809-1265

MRN: _____

DOB: _____

STANDARD REMICADE PLAN OF TREATMENT FOR DERMATOLOGY 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 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: 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 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 5 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