Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 **DOB: _____**

STANDARD REMICADE PLAN OF TREATMENT FOR RHEUMATOLOGY

(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: ☐ 714.0 Rheumatoid Arthritis ☐ 714.2 Other Rheumatiod Arthritis
☐ 696.0 Psoriatic Arthropathy* ☐ 720.0 Ankylosing Spondylitis* ☐ Other: _____

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 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