



MRN: _____

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

DOB: _____

Guidelines for Prescribing Remicade[®] (infliximab) for Dermatology

(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.

- Remicade[®] is indicated for **Psoriatic Arthritis & Plaque Psoriasis** at a dose of 5 mg/kg induction & then every 8 weeks.

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.