



MRN: _____

DOB: _____

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

STANDARD REMICADE® (infliximab) PLAN OF TREATMENT FOR GASTROENTEROLOGY

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: * Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing

- K50.0** _____ Crohn's Disease (small intestine) **K51.8** _____ Other Ulcerative (chronic) Colitis
- K50.1** _____ Crohn's Disease (large intestine) **K51.5** _____ Left sided Ulcerative (chronic) Colitis
- K50.8** _____ Crohn's Disease (small & large intestine) **K51.0** _____ Universal Ulcerative (chronic) Pancolitis
- K50.9** _____ Crohn's Disease, Unspecified **K51.9** _____ Ulcerative Colitis, Unspecified **K60.3** Anal Fistula
- K63.2** Fistula of Intestine Other **ICD-10 Code** (Diagnosis/Description): _____

4. Pre-medications: Administered 30 minutes prior to infusion as selected:

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

<p>a) Acetaminophen:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 650mgs PO <input type="checkbox"/> 500mgs PO <input type="checkbox"/> 325mgs PO 	<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</p> <p>c) Alternate oral antihistamine to diphenhydramine:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cetirizine 10 mg, <input type="checkbox"/> Loratadine 10 mg, Fexofenadine <input type="checkbox"/> 60mgs or <input type="checkbox"/> 180mgs <p>d) Other: Methylprednisolone <input type="checkbox"/> 40mgs IVP <input type="checkbox"/> 125mgs IVP or other _____ mgs IVP</p> <p>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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5. Dose: Remicade® (infliximab) 5 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. 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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Guidelines for Prescribing Remicade® (infliximab) for Gastroenterology
 (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 **Adult Crohn's Disease**: Dose of 5 mg/kg induction & then every 8 weeks. For patients who respond and then lose response, consider treatment with 10mg/kg. Patients who do not respond by 14 weeks are unlikely to with continued dosing.
 - **Pediatric Crohn's Disease, Adult and Pediatric Ulcerative Colitis**: Dose of 5mg/kg induction and 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:

- 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.