MRN:_____

DOB:_____

STANDARD REMICADE ® (infliximab) PLAN OF TREATMENT

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: **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.***

a) Acetaminophen:
- □ 650mgs PO
- □ 500mgs PO
- □ 325mgs PO

b) Diphenhydramine: □ 25 mgs PO, □ 50mgs PO, □ 25 mgs IVP, □ 50mgs IVP or

c) Alternate oral antihistamine to diphenhydramine:
□ Cetirizine 10 mg, □ Loratadine 10 mg, Fexofenadine □ 60mgs or □ 180mgs

d) Other: Methylprednisolone □ 40mgs IVP □ 125mgs IVP or other_____mgs IVP
Famotidine: □ 20mgs PO, □ 40mgs PO, □ 20mgs IVP, □ 40mgs IVP

e) Pre-medicate with other: _____

_____

Orders: Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.***

5. Dose:
☐ Remicade® (infliximab) 3 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. Frequency:
☐ 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: _____

MRN: _____

DOB: _____

Standard Guidelines for Prescribing Remicade ® (infliximab)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**

☐ 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.**

☐ 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.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.