



# REMICADE MEDICATION ORDER

Patient's Name (Last, First, Middle) \_\_\_\_\_ DOB \_\_\_\_\_

Patient's height in feet and inches \_\_\_\_\_ Patient's weight in pounds \_\_\_\_\_

**■ Diagnosis** *Please clearly specify the ICD10 code if using a diagnosis with a \_\_\_ noted.*

- Mo6.0 Rheumatoid arthritis w/o rheumatoid factor
- Mo6.8 Rheumatoid arthritis, other
- M40.0 Psoriasis vulgaris
- M45.\_\_\_\_\_ Ankylosing spondylitis (specific ICD10)
- M40.52 Psoriatic arthritis mutilans
- K51.9\_\_\_\_\_ Ulcerative colitis (specify ICD10)
- K50.9\_\_\_\_\_ Crohn's disease (specify ICD10)
- Other: \_\_\_\_\_

**■ Details Needed for Approval**

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? \_\_\_\_\_
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? If yes, circle all that apply. They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition?
- Will the patient be concomitantly prescribed methotrexate? \_\_\_\_\_ If not, please document contraindication or intolerance.
- If the patient has severe psoriatic arthritis or active ankylosing spondylitis, do they concomitantly also have the other? \_\_\_\_\_

**■ Infliximab IV Infusion Order** *Select all required*

- Remicade
- If a different infliximab product is preferred by the insurance carrier, or the brand selected is not procurable, it may be substituted, unless this box is checked.*

Dosage and Frequency:

- Initial dose of 3mg/kg at weeks 0, 2 and 6. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Initial dose of 5mg/kg at weeks 0, 2 and 6. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Maintenance dose of 3mg/kg every 8 weeks for \_\_\_\_\_ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Maintenance dose of 5mg/kg every 6 weeks for \_\_\_\_\_ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.
- Maintenance dose of 5mg/kg every 8 weeks for \_\_\_\_\_ months. Administered in 250ml normal saline over 2 hours to 2.5 hours.

**Utilize 1.2µ filtered tubing.** Post infusion flush with normal saline. Check vitals and monitor for signs and symptoms at start, throughout infusion, and after completion.

**■ Rescue Management in Case of Reaction**

*These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.*

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

**■ Ordering Provider Authorization**

Provider Signature: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Indiv. NPI #: \_\_\_\_\_ License: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_ Direct Phone to Contact Person: \_\_\_\_\_

**Documentation to Include:**

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

**FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.**