REMICADE HOME INFUSION REFERRAL FORM

PATIENT INFORMATION					
Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

INSURANCE INFORMATION
❑ **Please attach front and back of patient's insurance card (medical and prescription)**

PRESCRIBER INFORMATION			
Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:	Practice Name:		
Address:	City:	State:	Zip:
Phone: Fax:	Key Office Contact:	Phone:	

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: ❑Rheumatoid Arthritis ❑Crohn's Disease ❑Ankylosing Spondylitis ❑Ulcerative Colitis ❑Psoriatic Arthritis ❑Plaque Psoriasis ❑Psoriasis with Arthropathy ❑Other_____

- Has patient been treated previously for this condition? ❑Yes ❑No Medication(s):_____
- Is patient currently on therapy? ❑Yes ❑No Medication(s):_____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No
  - If yes: How long should patient wait before starting the new medication? _____
- Medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

  _____
- Has patient received a PPD (tuberculosis) Skin Test or QuantiFeron TB GOLD Test? ❑Yes ❑No Results: _____
  - Prior to initiating treatment and periodically during therapy, patient should be evaluated for active tuberculosis and tested for latent infection.

PRESCRIPTION INFORMATION

1. Assess patient for signs/symptoms of infection; notify MD if present prior to proceeding.
2. Obtain baseline vital signs (T, P, R, BP)
3. First Remicade Infusion: ❑Yes ❑No
4. Establish Intravenous Access (Peripheral IV) unless patient already has a line (PICC)
5. Does pt already have a line? ❑Yes ❑No If yes, type of line_____med(s) that is/are infused via that line _____
6. Remicade to be infused via the existing line? ❑Yes ❑No If yes, wash out period with other med(s) that is/are infused via the same line_____
7. **Labs before infusion:** ❑AST ❑ALT ❑Alk Phos ❑Tbili ❑Albumin ❑Lytes ❑BUN ❑SrCr ❑CBC with differential ❑CBC without differential ❑Other_____
8. Remicade Dose Calculation:
   ❑Round off to finish 100 mg vial, maximum dose: 10 mg/Kg; Dose more than 5 mg/Kg should NOT be administered to pt with moderate to severe heart failure
   Patient's weight in Kg_____ (date of weight taken:_____)

Starting Dose: Qty: QS

- ❑ 5 mg/Kg mg IV at wk: 0, 2, 6 (infusion over a period NOT less than 2 hours)
- ❑ 3 mg/Kg_____mg IV at wk: 0, 2, 6 (infusion over a period NOT less than 2 hours)
- ❑ Other _____

Maintenance Dose: Qty: QS Refills: _____

- ❑ (_____mg/Kg)_____mg IV q___ wks for_____infusions (infusion over a period NOT less than 2 hours)
- ❑ Other _____

9. **Flushing:** Flush PIV with 3 - 5 ml NaCl 0.9% per nursing agency protocol. Qty: 30 ml Refills: _____
10. **Ancillary supplies:** for administration of treatment *(use 21 gauge or less needle)*
11. **Hydration (optional):** Start IV with NaCl 0.9% running at 50 ml/hr Qty: #1 x 100 ml Refills: _____
12. **Pre-Medication (optional):** Pre-medicate 30 minutes prior to infusion
    a. ❑ Acetominophen 650 mg po x 1 Qty: #2 x 325 mg Refills: _____
    b. ❑ Diphenhydramine 25 mg-50 mg ❑po ❑IVP (rate not to exceed 25mg/minute) Qty: QS (2 x 25mg cap or 50mg/ml)
    c. Patient with prior history of infusion reaction, give: Prednisone 50 mg po **OR** Solu-Medrol 40 mg slow IVP in addition to Diphenydramine and Acetaminophen
       ❑ Prednisone 50 mg po **OR** ❑Solu-Medrol 40 mg slow IVP over several minutes Qty: #5 x 10 mg **OR** Qty: #1x 40 mg vial
    d. ❑ Other: _____ Qty: _____ Refills: _____
13. **Medication Preparation:**
    a. Reconstitute each vial with 10 ml SWFI (Sterile Water For Injection), swirl gently, DO NOT SHAKE Qty: QS 10 ml SWFI
    b. Let stand for 5 minutes
    c. Dilute the total volume of the reconstituted Remicaide solution dose to 250 ml NS, by withdrawing a volume of NS equal to the volume of reconstituted Remicaide from the 250 ml NS bag. Gently mix. (Final Concentration: 0.4 mg/ml - 4 mg/ml) Qty: 250 ml NS
    d. Use standard IV tubing with in-line, non-pyrogenic, low-protein-binding filter (pore size of 1.2 micron or less)

Please see second page

14. **Infusion Rate:** Set IV rate to infuse 250 ml IV bag over a period not less than 2 hours as tolerated by patient as directed

Recommended Infusion Rate Schedule	
Time (min)	**Infusion Rate**
0	10 ml/hr x 15 minutes
15	20 ml/hr x 15 minutes
30	40 ml/hr x 15 minutes
45	80 ml/hr x 15 minutes
60	150 ml/hr x 30 minutes
90	Increase rate as tolerated by patient q 30 min Maximum Rate: 250 ml/hr
120 minutes or more	End of Therapy

Alternative Rate of Infusion: _____

15. **Monitoring:** Monitor patient's vital signs and tolerance every 15-30 minutes. Watch for fever, chills, pruritis, chest pain, BP changes or dyspnea.
    a. Check blood pressure, pulse, temperature every 15 min for the first hr then every 30 min until infusion is completed.
    b. Hold infusion and notify MD if patient develops fever, chills, rash, hives, or itching
    c. Hold infusion and notify MD if signs and symptoms of hypersensitivity occur: urticaria, dyspnea, hypotension, fever, rash , headache, sore throat, myalgia, polyarthralgias, hand and facial edema, dysphgia, pruritus, flushing, angioedema which may have upper airway involvement, chest discomfort, respiratory symptoms.
    i. Follow MD's instructions and discontinue infusion for severe reactions.
    d. Symptoms related to the method of administration: pruritus, burning, swelling at the site of venipuncture, abscess at the site of venipuncture.
    e. Other symptoms: Headache, dizziness, back pain, fatigue.

16. **Managing Infusion Related Events:**

For Hypersensitivity:

a. Hold infusion and notify MD
b. Give:
- ❑ Diphenhydramine 25-50 mg IVP (Rate not to exceed 25 mg/min) q 4 hrs prn itching, hives, or rash (max dose/day: 400 mg/day). Qty: #3 x 50 mg/ml vial
- ❑ Acetaminophen 650 mg po x 1 Qty: #2 x 325 mg
- ❑ Solu-Medrol 125 mg slow IVP (over several minutes) Qty: #1 x 125 mg vial
- ❑ For Nausea, give Phenergan 25 mg ❑po x 1 ❑IV x 1 Qty: QS (25 mg tab or 25mg/ml)
- ❑ If hypotension occurs, stop infusion. **NOTIFY MD** and get an order to use: NS_____ml (10 ml/Kg) IV-bolus. QTY:_____ml

c. Monitor vital signs every 2 -10 minutes until normal. If reaction is resolved resume infusion by MD's permission at 10 ml/hr and follow the infusion rate schedule as tolerated by patient.

For Anaphylaxis

a. If reaction is unresolved or more severe, stop infusion:
b. Call MD and 911
c. Give:❑ Epinephrine (1:1000) 0.5 mg SQ, may repeat q20 minutes x 2 Qty: #3 x 1 ml
d. Monitor vital signs more frequently

17. Observe patient for an additional 30 minutes after conclusion of infusion.
18. If vital signs are stable, discontinue IV and discharge patient
19. Monitor signs and symptoms of infection; during and after therapy. Remicade should NOT be given to patient with clinically important, active infection.
20. If patient develops a serious infection, Remicade therapy should be discontinued.
21. **Patient Education:** Educate patient on Remicade possible side effects, allergic reactions, delayed allergic reactions, and when to contact MD.
    a. Most common side effects of Remicade: respiratory infections, such as sinus infection and sore throat, headache, rash, coughing, stomach pain
    b. Educate patient to contact MD with the following allergic reactions (may occur during or shortly after infusion): hives, difficulty breathing, chest pain, high or low BP, fever, chills.
    c. Educate patient about signs and symptoms of delayed allergic reactions which may occur 3 to 12 days after receiving Remicade infusion and notifying MD immediately if following occur: fever, rash, headache, sore throat, muscle or joint pain, swelling of the face and hands, difficulty swallowing.
22. **Laboratory Order:** Labs to be drawn and monitored by MD's office unless they are ordered on this form (please see page 1).
    a. Discontinue Remicade if LFT *more than* 5 times upper limit of normal.
    b. All necessary tests/labs prior to and/or during Remicade infusion have been done/or will be done by MD's office and AcariaHealth can start/continue Remicade infusion as soon as receiving the signed order or Remicade home infusion

Please make necessary changes in the protocol then sign/date and fax both pages back to AcariaHealth at 877-541-1503

Physician's Signature: _____ ❑ DAW (Dispense as Written)

Date____/_____/____

Prescriber certifies that this referral form contains an original signature and is signed by the treating physician. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

Phone: 800.511.5144 ● Fax: 877.541.1503