Boni Besselman

ORANGE REGIONAL MEDICAL CENTER

Infliximab (Remicade®) Orders

TO BE COMPLETED BY PRESCRIBER Patient Name: Boni Besselman DOB: 8-31-55

Date Written: Date of Administration:

Height: 5 ft 3 in
Weight: 153 kg lbs

IV fluid during therapy
☑ Sodium Chloride 0.9% IV @ 20 mL/hour
☐ Other: _____ IV @ _____ mL/hour

Allergies:
(please list reactions)
☐ NKDA
penicillin
Sulfa
Codeine
Adhesive Tape
PPD 8-21-19

Pre-medication: Administer 30 minutes prior to infliximab
☐ Acetaminophen (Tylenol®) 650mg orally
☐ Diphenhydramine (Benadryl®) 25mg orally
☐ Diphenhydramine (Benadryl®) 25mg IV push
☐ Hydrocortisone (Solu-Cortef®) 100mg IV push
☐ Methylprednisolone (Solu-Medrol®) 40mg IV push
☑ Other: Benadryl IV 50mg

induction 0, 2, 6 every 8 weeks

Infliximab (Remicade®) Indications: Strict adherence to criteria for each indication is necessary for proper reimbursement; all criteria to be met unless otherwise specified.

☐ **Crohn's Disease** (for patients six years of age or older)
1. Moderately to severely active disease to induce and maintain clinical remission in patients who have failed or are intolerant of conventional therapy. Conventional therapy administered: _____ OR
2. Reduction of draining enterocutaneous or rectovaginal fistulas in a patient with disease for at least 3 months OR
3. For maintenance therapy for a patient with moderately to severely active disease who has previously responded to infliximab.

☑ **Ulcerative Colitis** (for patients six years of age or older)
1. Moderately to severely active disease in patients who have failed or are intolerant of conventional therapy. Conventional therapy administered: _____

☐ **Rheumatoid Arthritis** (for patients 18 years of age or older with active PsA)
1. In combination with methotrexate or another immunosuppressive agents (due to intolerance of methotrexate) AND
2. Patient has failed to respond or is intolerant of one or more nonbiological DMARDs. DMARD administered: _____

☐ **Ankylosing Spondylitis** (for patients 18 years of age or older)
1. Patient has failed to respond or is intolerant of conventional therapy. Conventional therapy administered: _____

☐ **Psoriatic Arthritis (PsA)** (for patients 18 years of age or older with active PsA)
1. Patient has failed to respond or is intolerant of conventional therapy. Conventional therapy administered: _____

☐ **Plaque Psoriasis** (for patients 18 years of age or older)
1. Plaque Psoriasis involving greater than five percent body surface area OR
2. Plaque Psoriasis involving less than or equal to five percent body surface area involving sensitive areas or areas that significantly impact daily function (e.g. palms, soles of feet, head/neck, genitalia AND)
3. Patient has failed to respond or is intolerant to phototherapy or other systemic therapy. Therapy administered: _____

☐ **Juvenile Idiopathic Arthritis** (for patients 2 years of age or older)
1. Moderately to severely active disease AND
2. Patient has failed to respond or is intolerant to one or more nonbiological DMARDs. DMARD administered: _____

Not Medically Necessary: Applies when criteria for the indications listed above are not met, and all other indications not listed above, as well as:
1. In combination with other TNF antagonists; OR
2. In combination with the following non-TNF immunomodulatory medications: abatacept (Orencia®), anakinra (Kineret®), tocilizumab (Actemra®) OR
3. Tuberculosis, invasive fungal infection, other serious infections, or a history of recurrent infections OR
4. Patient has not had a tuberculin skin test or Centers for Disease Control recommended equivalent to evaluate for latent tuberculosis.

Investigational and Not Medically Necessary: Applies when criteria are not met and for all other indications, including, but not limited to treatment of asthma, Behcet's syndrome, chronic obstructive pulmonary disease, disc-herniation-induced sciatica, hairy cell leukemia, graft versus host disease, hidradenitis suppurativa, neurosarcoidosis, sarcoidosis, Still's disease, Sjogen's syndrome, Takayasu arteritis, and Wegener's granulomatosis.

Prescribers: Note, consider the status of an individual with moderate or severe heart failure New York Heart Association Functional Class III-IV before initiating treatment with infliximab at doses greater than 5 mg/kg.

Infliximab (Remicade) Dose: 5 mg/kg Total dose: 765 mg
(To be rounded to nearest vial size within 10% of written dose, per policy)
Infuse over at least 2 hours, per protocol, following titration schedule.

MD Name (Print): Alan Plumer MD Signature: _____ Date/Time: 1-7-20

Physician Orders/Blank/Infliximab(Remicade)/Pharmacy/7-14

CVS caremark

Notice of Approval

Date: 05/22/2019

BONI BESSELMAN
121 COUNTRY CLUB DRIVE
FLORIDA, NY 10921

Plan Member Name: BONI BESSELMAN
Plan Member ID: ********3602

Prescriber Name: ALAN PLUMER
Prescriber Phone: 1-8456154000
Prescriber Fax: 1-8456154002

Dear BONI BESSELMAN:

CVS Caremark® received a request for coverage of Remicade for you.

As long as you remain covered by your prescription drug plan and there are no changes to your plan benefits, this request is approved for the following time period:

05/22/2019 - 05/22/2021 OK aa 5-22-19

Approvals may be limited as follows:

- By dosing limits. Dosing limits may be established in accordance with FDA approved labeling, accepted compendia, evidence based practice guidelines or your prescription drug plan benefits;
- By indication. For some products, coverage may be available for select indications only;
- By National Drug Code (NDC). Drug products are identified by unique numerical product identifiers, called NDCs, which identify the manufacturer, strength, dosage form, formulation and package size. Some NDCs may not be covered.

The prescription drug plan requires that this medication be filled through CVS/Specialty Pharmacy. If you have not done so already, a prescription can be faxed to 1-800-323-2445 along with a copy of this letter and the request will be processed.

If you have any questions, please call Customer Care toll-free at the number on your benefit ID card or in your benefit plan materials.

BlueCross BlueShield of Texas

Subscriber Name :
Member Name : BONI BESSELMAN
Member Address : 121 COUNTRY CLUB DRIVE
FLORIDA, NY 10921-1552
Request ID : 19113AADRH

OK 5-20-19

May 15, 2019

Dear BONI BESSELMAN:

This letter is in response to a request for service(s)/procedure(s). The following service(s)/procedure(s) has been approved as medically necessary as defined by the member's Health Care Benefits booklet or Summary Plan Description.

Member Name:	BONI BESSELMAN
Date of Birth:	AUGUST-31-1955
Subscriber ID:	821383050
Request ID:	19113AADRH
Physician:	Alan Plumer
Total Days/Units of Service:	8
Treatment Setting:	Outpatient
Onset of Service:	APRIL-22-2019

Service Procedure Code/Description: J1745 - Injection, infliximab, excludes biosimilar, 10 mg

Begin Date	End Date	Days/Units Approved
05/22/2019	04/22/2020	6

Note for Provider:Service codes that do not require medical review are processed as approvals unless these services(codes) are ancillary to a primary service which has been denied or lacks contractual benefit.

Please contact the phone number on the back of your card prior to the above listed expiration date if an additional review of benefits is needed for further days/units of service. In order to ensure coverage, Blue Cross and Blue Shield of Texas must also be notified if any of the following occur:

- The treatment plan or level of care is changed.
- The ordering physician or facility is changed from that noted above.
- The date of service is changed or cancelled.

Approval through the Health Care Management Department is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in your Certificate of Benefits Booklet and/or Summary Plan Description as well as the preexisting condition waiting period, if

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BESSELMAN, BONI, F, 08/31/1955

845-551-4359

HMG Goshen GI-30 Hatfield
30 Hatfield Lane, Suite 107 , Goshen, NY 10941-7104
845-703-8606

FINAL RESULT

Accession ID: 1086656	Lab Ref ID: 7496208
Order Date: 02/21/2019	Result Recd: 02/27/2019 15:14:05
Coll. Date: 02/22/2019 12:40:00	Report: 02/22/2019 12:40:00
Requesting Physician: Plumer, Alan	Ordering Physician: Plumer, Alan

QUANTIFERON TB GOLD+,1T

NAME	VALUE	REFERENCE RANGE
F QUANTIFERON PLUS,1T	Negative	Negative
- Negative test result. M. tuberculosis complex infection		
- unlikely.		
F NIL	0.02	(IU/mL)
F MITOGEN-NIL	>10.00	(IU/mL)
F TB1-NIL	0.01	(IU/mL)
F TB2-NIL	0.01	(IU/mL)
- The Nil tube value reflects the background interferon		
- gamma immune response of the patient's blood sample.		
- This value has been subtracted from the patient's		
- displayed TB and Mitogen results.		
-		
- Lower than expected results with the Mitogen tube		
- prevent false-negative Quantiferon readings by		
- detecting a patient with a potential immune		
- suppressive condition and/or suboptimal pre-analytical		
- specimen handling.		
-		
- The TB1 Antigen tube is coated with the		
- M. tuberculosis-specific antigens designed to elicit		
- responses from TB antigen primed CD4+ helper		
- T-lymphocytes.		
-		
- The TB2 Antigen tube is coated with the		
- M. tuberculosis-specific antigens designed to elicit		
- responses from TB antigen primed CD4+ helper and CD8+		
- cytotoxic T-lymphocytes.		
-		
- For additional information, please refer to		

NAME	VALUE	REFERENCE RANGE
- http://education.questdiagnostics.com/faq/204		
- (This link is being provided for informational/		
- educational purposes only.)		
NON-FASTING		

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Accession ID: 1086656