

Methylprednisolone (Solu-Medrol)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____kg Height: ____cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____				
<p style="text-align: center;">Diagnosis</p> <input type="checkbox"/> Adrenal Insufficiency, unspecified (E27.40) <input type="checkbox"/> Unspecified asthma, not otherwise specified (J45.909) <input type="checkbox"/> Chronic obstructive pulmonary disease, unspecified (J44.9) <input type="checkbox"/> Allergy, unspecified (T78.40) <input type="checkbox"/> Systemic involvement of connective tissue, unspecified (M35.9) <input type="checkbox"/> Multiple sclerosis (G35) <input type="checkbox"/> Arthritis, unspecified (M06.9) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____	<table style="width: 100%;"> <tr> <th style="text-align: left; width: 50%;">Labs</th> <th style="text-align: left; width: 50%;">Frequency</th> </tr> <tr> <td> <input type="checkbox"/> CMP <input type="checkbox"/> CBC </td> <td> <input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____ </td> </tr> </table>	Labs	Frequency	<input type="checkbox"/> CMP <input type="checkbox"/> CBC	<input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____
Labs	Frequency				
<input type="checkbox"/> CMP <input type="checkbox"/> CBC	<input type="checkbox"/> Every infusion <input type="checkbox"/> Other: _____				
Previously tried and failed therapies (include dates): _____					
<p>Methylprednisolone sodium succinate (Solu-medrol) in sodium chloride 0.9% IVPB 100ml</p> <p>Important note: Administer doses >250 mg over at least 30 to 60 minutes Do not administer acetate form IV</p>					
<p style="text-align: center;">Dose</p> <input type="checkbox"/> 250 mg <input type="checkbox"/> 500 mg <input type="checkbox"/> 750 mg <input type="checkbox"/> 1,000 mg <input type="checkbox"/> _____ mg	<p style="text-align: center;">Frequency</p> <input type="checkbox"/> daily for _____ doses <input type="checkbox"/> weekly <input type="checkbox"/> every 4 weeks <input type="checkbox"/> other: _____ Date of last infusion: ____/____/____				

Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____	Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care	<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ </div> <div> Provider Signature: _____ </div> </div> <div> <div> Attending Physician Name: _____ </div> <div> Provider NPI: _____ </div> </div> <div> <div> Office Phone Number: _____ </div> <div> Office Fax Number: _____ </div> </div> <p>(If ordering provider is an advanced practice practitioner)</p> <p>Note: This order is valid for 12 months from date of physician signature.</p>		