

An Outpatient Department of St. Mary's Hospital  
2421 Malcom Bridge Rd Ste 820 Bogart, GA 30622-2325  
Phone: 706-389-7802  
Fax: 706-389-2501

### 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

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

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| <b>Pre-Medications and Pre-Protocol</b><br>(ordered at physician discretion)                                                                                                                                                                                                                                  | <input type="checkbox"/> Acetaminophen 650 mg PO once<br><input type="checkbox"/> Loratadine 10 mg PO once<br><input type="checkbox"/> Diphenhydramine once<br><input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg<br><input type="checkbox"/> PO <input type="checkbox"/> IV<br><input type="checkbox"/> Famotidine 20 mg IV once<br><input type="checkbox"/> Hydrocortisone 100 mg IV once<br><input type="checkbox"/> Methylprednisolone 125 mg IVP once<br><input type="checkbox"/> Other: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Hydration</b><br><input type="checkbox"/> LR<br><input type="checkbox"/> Sodium Chloride 0.9%<br><input type="checkbox"/> Other _____<br><br>_____ mL at _____ mL/hr<br><input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following |
| <b>Flushing Protocol</b><br><i>as needed for line care</i>                                                                                                                                                                                                                                                    | <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> Heparin 100 Units/mL <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL                                                                                                                                                                    |
| <b>Hypersensitivity Panel</b><br>Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary                                                                                                                                                    | <ul style="list-style-type: none"> <li>• <b>Sodium chloride</b> 0.9% bolus 500 mL once as needed for hypotensive management (SBP &lt;90mmHg)</li> <li>• <b>Acetaminophen</b> 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping</li> <li>• <b>Albuterol</b> 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses</li> <li>• <b>Albuterol HFA</b> inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea</li> <li>• <b>Epinephrine</b> injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses</li> <li>• <b>Famotidine</b> 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</li> <li>• <b>Diphenhydramine</b> 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</li> <li>• <b>Diphenhydramine</b> 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</li> <li>• <b>Hydrocortisone</b> 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</li> </ul> |                                                                                                                                                                                                                                                                               |
| <div> <div> Provider Name: _____<br/> Attending Physician Name: _____<br/> Office Phone Number: _____<br/> <br/> <i>Note: This order is valid for 12 months from date of physician signature.</i> </div> <div> Provider Signature: _____<br/> Provider NPI: _____<br/> Office Fax Number: _____ </div> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                               |