Methylprednisolone (Solu-Medrol)

Provider Order Form rev. 10/30/2023

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

RA w/rheumatoid factor, multiple sites: RA w/o rheumatoid factor, multiple sites:

Rheumatoid arthritis of unspecified site with involvement of organs and systems:

Rheumatoid arthritis with rheumatoid factor of unspecified site w/o organ or systems involvement:

systemic lupus erythematosus with organ or system involvement, unspecified:

Arthropathic psoriasis, unspecified: Other psoriatic arthropathy:

Ankylosing spondylitis of unspec. sites in spine: Ankylosing spondylitis of multiple sites in spine:

Systemic lupus erythematosus, unspecified:

Other: Description:

THERAPY ADMINISTRATION & DOSING *(Choose one)*

☐ Administer Methylprednisolone (Solu-Medrol) 500 mg in 100 ml 0.9% sodium chloride. Infuse over at least 30 minutes[1]

☐ Administer Methylprednisolone (Solu-Medrol) 1000 mg in 250 ml 0.9% sodium chloride. Infuse over at least 30 minutes[1]

☐ Administer Methylprednisolone (Solu-Medrol) _____ mg in _____ ml 0.9% sodium chloride over at least _____ minutes

[1]Doses 500 mg or greater should be infused over at least 30 minutes; Tolerability may improve for some patients when infused over 60 minutes.

FREQUENCY

☐ Administer once daily for a total of _____ doses.

☐ Ok to leave IV to saline lock for treatment on consecutive days

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for signs or symptoms of illness or active infection.

☑ DO NOT use 40mg vial for patient with a dairy allergy.

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindication and reason for needing medication

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.