

# Methylprednisolone (Solu-Medrol)



Provider Order Form rev. 10/4/2021

## PATIENT INFORMATION

Date:	Patient Name:	DOB:
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	
<b>Patient Status:</b> <input type="checkbox"/> New to Therapy <input type="checkbox"/> Continuing Therapy	Next Due Date (if applicable):	

## PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:		
Ordering Provider:	Provider NPI:		
Referring Practice Name:	Phone:	Fax:	
Practice Address:	City:	State:	Zip Code:

## NURSING

- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation  
**NOTE:** IVX Adverse Reaction Management Protocol available for review at [www.ivxhealth.com/forms](http://www.ivxhealth.com/forms) (version 09.07.2021)

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_  
 CMP  at each dose  every \_\_\_\_\_  
 Other: \_\_\_\_\_

## PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg /  650mg /  1000mg PO  
 cetirizine (Zyrtec) 10mg PO  
 loratadine (Claritin) 10mg PO  
 diphenhydramine (Benadryl)  25mg /  50mg  PO /  IV  
 hydrocortisone (Solu-Cortef) 100mg IV  
 Other: \_\_\_\_\_  
Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Frequency: \_\_\_\_\_

## THERAPY ADMINISTRATION

- Methylprednisolone** (Solu-medrol) in 0.9% sodium chloride, intravenous infusion
- Dose:  250mg /  500mg /  1000mg /  other \_\_\_\_\_
  - Frequency:  daily x \_\_\_\_\_ doses /  other \_\_\_\_\_
  - Mix in:  100ml NS /  250ml NS /  500ml NS /  other \_\_\_\_\_
  - Infuse over  30 minutes /  60 minutes /  other \_\_\_\_\_
- Flush with 0.9% sodium chloride at infusion completion
- Patient is required to stay for 30-minute observation post infusion/injection  
 Patient is NOT required to stay for observation time  
 Refills:  Zero /  for 12 months /  \_\_\_\_\_  
(if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

Provider Name (Print)	Provider Signature	Date
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Email [ivxintake@ivxhealth.com](mailto:ivxintake@ivxhealth.com) or fax this form, insurance card (both sides), demographics, recent H&P, labs, and supporting clinicals to:

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> BAY AREA: 844-899-0275   | <input type="checkbox"/> COLUMBUS: 844-627-2675     | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN: 888-615-1445   |
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