Methylprednisolone (Solu-Medrol)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

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

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ Primary Diagnosis:

☐ Secondary Diagnosis:

PRIMARY MEDICATION ORDER

Methylprednisolone (Solu-medrol) in 0.9% sodium chloride, intravenous infusion

• Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation

• Order valid for 12 months unless otherwise noted: _____

• **Infuse over:** ☐ 30 minutes
☐ 60 minutes
☐ Other: _____

DOSE	FREQUENCY	MIX IN
☐ 250mg	☐ Daily x _____ doses	☐ 100ml NS
☐ 500mg	☐ Other:	☐ 250ml NS
☐ 1000mg		☐ 500ml NS
☐ Other: _____		☐ Other: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Solu-Medrol

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Other: _____

Dose: _____ Route: _____

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ Other: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

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