BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

# METHYLPREDNISOLONE ORDERS

| REFERRAL CHECKLIST |
| --- |
| Please ensure the following information is included with your referral: |
| ☐ Patient Demographics and Contact Information |
| ☐ Patient Insurance Information |
| ☐ Completed H&P and Progress Notes Including Medications and Allergies |
| ☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis |
| ☐ Completed and Signed Referral |
| Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient.<br>Thank you! |

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Print, complete, and fax completed form to (406) 752-0443

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# METHYLPREDNISOLONE ORDERS

| PATIENT INFORMATION | PRESCRIBER INFORMATION |
|---|---|
| Patient Name: | Prescriber Name: |
| Address: | NPI: |
| City, State, Zip: | Address: |
| Cell: Email: | City, State, Zip: |
| Ht: Wt: kg Last 4 of SSN: DOB: | Phone: Fax: |
| Allergies: | Contact Person: |

| REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change | |
|---|---|
| First dose? ☐ Yes ☐ No - Date of last infusion: | Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other |

| DIAGNOSIS |
|---|
| ☐ Dx Code/description: |

**REQUIRED DOCUMENTATION** ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

**PRESCRIBING INFORMATION**

**MEDICATION**

| Medication | Strength | Dose/Directions | Quantity |
|---|---|---|---|
| ☒ **Methylprednisolone** | 125mg vial<br>OR<br>1,000mg vial | ☐ mg daily x 5 doses<br>☐ mg every x doses<br>☐ Infuse in 0.9%NS for a concentration of 10mg/ml IV over 30 minutes | ☒ #vials sufficient for dose<br>Refills: |

***If not specified, order will be valid for 1 year from the date of signature.***

| NURSING INSTRUCTIONS/EMERGENCY MEDICATION | |
|---|---|
| RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines<br>Post-Infusion:Use 50ml0.9%NS to flush residual priming volume | PIV:Flush 3-10mL0.9%NS before/after<br>PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final |

Administer the following medications as needed for infusion-related reactions per company protocol:
**Adults>40kg:**Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
**Pediatrics/Adults<40kg:**Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
**Oxygen(AIC/AIS only):**1-6L/min via NC/face mask; titrate to maintain $SpO_2$ 95-100%.

**Prescriber Signature X:** _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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