Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265

Standard Plan of Treatment for Methylprednisolone

(Re)Certification Period From_____to_____

Note: We may require MD office notes and may require a letter of Medical Necessity (depending on diagnosis), to be able to verify eligibility and payment for this treatment through patients Medicare and/or other insurance plan.

Patient's Name _____ **Weight:** _____

Allergies:_____ **Height:**_____

Primary Diagnosis_____Secondary Diagnosis: _____

ORDERS:

Obtain weight each visit. Vital Signs: baseline and every 30 minutes until infusion complete
Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient response to therapy.
Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% or D5W 20-50 ml to flush tubing/line, followed by Heparin Lock 1-5ml 100 units/ml as needed per line type.
For home infusion patients: NS flush of 3-10ml pre/post infusion.
Pump, tubing, and supplies needed to complete prescribed therapy.
If adverse drug reaction, Implement the Standing Adverse Reaction protocol.

Drug:

□ Methylprednisolone _____mg in _____ ml NS IV over _____hr(s) for _____ day(s)

every ____month(s)

□ Other: _____
.
Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures please)

Physician's Signature: _____/ _____Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name:_____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO:

866-872-8920