MRN:_____

DOB:_____

Standard Plan of Treatment for

NOTE: *We may require a detailed Letter of Medical Necessity or clinical supporting documentation (depending on diagnosis), to be able to verify eligibility and payment for this treatment through Medicare and/or other insurance plans.* Patient ***may be ineligible*** to receive treatment if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, and/or surgery.

1. Patient Name:_____Height (inches):_____Weight (lbs):_____

2. Allergies:_____

3. Diagnosis: ☐ Primary ICD-**10 Code:**_____**Diagnosis description:** _____

☐ **Other ICD-10 Code:**_____**Diagnosis description:** _____

Orders: Obtain weight each visit. Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Pump, tubing, 0.22- micron filter, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.***

4. Drug: Methylprednisolone_____mg IV in 100-250 ml of Sodium Chloride 0.9% infused per protocol

5. Frequency: ☐ Once ☐ Daily x_____dose (s) ☐ Weekly x ____ ☐ Monthly x _____

☐ Other: _____

Special Orders: _____

6. Physician's Signature:_____/_____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials:_____NPI: _____

MRN: _____

DOB: _____

Guidelines for Prescribing for Methylprednisolone

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:** _____

☐ Include signed and completed **Plan of Treatment**.

☐ Include patient demographic information and insurance information. (Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

☐ Other as requested: _____

_____

_____

** Warnings/Precautions: **Serious Infections:** Infections General Patients who are on corticosteroids are more susceptible to infections than are healthy individuals. There may be decreased resistance and inability to localize infection when corticosteroids are used. Infections with any pathogen (viral, bacterial, fungal, protozoan, or helminthic) in any location of the body may be associated with the use of corticosteroids alone or in combination with other immunosuppressive agents. **Fungal infections:** Corticosteroids may exacerbate systemic fungal infections and therefore should not be used in the presence of such infections unless they are needed to control drug reactions. **Vaccination:** Administration of live or live, attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of corticosteroids. Killed or inactivated vaccines may be administered. However, the response to such vaccines cannot be predicted. **Antidiabetics:** Because corticosteroids may increase blood glucose concentrations, dosage adjustments of antidiabetic agents may be required. See full prescribing information

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.