Palmetto INFUSION

MRN: _____
DOB: _____

Standard Plan of Treatment for Methylprednisolone

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:** _____

4. Drug:

Methylprednisolone _____ mg IV in 100-250 ml of Sodium Chloride 0.9% infused over 1 hour

5. Frequency:

☐ Once ☐ Daily x _____ dose(s) ☐ Weekly x ____ ☐ Monthly x _____ ☐ Other: _____

Special orders: _____
_____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

6. Physician's Signature: _____/ _____Date: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____NPI: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com

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MRN: _____

DOB: _____

Guidelines for Prescribing for Methylprednisolone

(Required documentation with all initial referrals)

Patient Name: _____ Referral Date: _____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ 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

Palmetto Infusion Services 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.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.