

|  |                                       |
|--|---------------------------------------|
| Referral Status:                       | MRN:                                  |
| <input type="checkbox"/> New referral  | <input type="checkbox"/> Order change |
| <input type="checkbox"/> Order Renewal |                                       |
| Patient preferred clinic:              |                                       |

## Methylprednisolone Standard Plan of Treatment

### PATIENT DEMOGRAPHICS:

|                   |                   |
|-------------------|-------------------|
| Date of Referral: | Patient's Phone:  |
| Patient Name:     | Address:          |
| Date of Birth:    | City, State, Zip: |
| Height in inches: | Weight: LB or KG  |
| Gender:           | Allergies:        |
|                   | See list          |
|                   | NKDA              |

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

|  |          |
|--|----------|
|  | - Other: |
|  | - Other: |

### REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

|   |                                |                  |  |
|---|--------------------------------|------------------|--|
| 1 | Insurance information          | IF NO:           | IF YES:  |
| 2 | Most recent History & Physical | PLEASE STATE     | LAST INFUSION DATE:                                    |
| 3 | Full medication list           | REQUIRED WASHOUT | NEXT INFUSION DATE:                                    |
| 4 | Tried and failed therapies     | FROM PREVIOUS    | <b>IF ORDER CHANGE:</b>                                |
| 5 |                                | THERAPY:         | <input type="checkbox"/>                               |
| 6 |                                |                  | <b>Continue current order until insurance approved</b> |

### MEDICATION ORDERS:

NOTE: 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.

### MEDICATION/DOSE:

Methylprednisolone \_\_\_\_\_ mg IV in 100-250mL of NS infused over 1 hour

### FREQUENCY:

Once

Daily x \_\_\_\_\_ (doses)

Weekly x \_\_\_\_\_ (doses)

Monthly x \_\_\_\_\_ (doses)

Other: \_\_\_\_\_


### SPECIAL/LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

Refills: \_\_\_\_\_

### NURSING ORDERS: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

|  |   |   |
|--|---|---|
| <input checked="" type="checkbox"/> Start PIV/Access CVC<br><input checked="" type="checkbox"/> Flush device per facility standard flushing procedure<br><input checked="" type="checkbox"/> Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated | Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here. |  |
|--|---|---|

### PRESCRIBER INFORMATION:

|                   |        |
|-------------------|--------|
| PROVIDER NAME:    | PHONE: |
| ADDRESS:          | FAX:   |
| CITY, STATE, ZIP: | NPI:   |

### PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

|   |                        |
|---|------------------------|
|   |                        |
| Dispense as written/Brand medically necessary | Substitution permitted |



## Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- 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.**

Palmetto Infusion 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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)