



Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Methylprednisolone Order Form

Patient Name: _____ DOB: _____
Phone: _____ Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Sex: _____ Height: _____ Weight: _____ Allergies: _____

DIAGNOSIS:

- ☐ Rheumatoid Arthritis ICD-10: G 35
☐ Other: _____ ICD-10: _____

ORDER FOR METHYLPREDNISOLONE (SOLU-MEDROL):

- ☐ Methylprednisolone 1 gram IV x **3 days**
☐ Methylprednisolone 1 gram IV x **5 days**
☐ **Other Dose:** _____ **Frequency:** _____

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☒ Nevada Infusion Hypersensitivity Reaction Order Set
☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line

FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml

NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI: _____
Physician Signature: _____ Date: _____
Point of Contact: _____ Phone: _____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

****Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. ****



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Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

- ☐ Signed provider orders (page 1)
- ☐ Patient demographic and insurance information
- ☐ Patient's current medication list
- ☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
- ☐ Supporting documentation to include past tried and/or failed therapies
- ☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
- ☐ Other medical necessity: _____

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