PREMIER VITALITY

Physician-led · Patient-centered · Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
**FAX: 410-220-2553**

## SOLUMEDROL ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**

| | | |
|---|---|---|
| Referring Office: | Contact Name: | Date: |
| Direct Phone for Contact: | Fax: | |
| Patient Name: | DOB: | |

Allergies ☐ NKDA ☐ Allergies:

Height:

Weight:

**Indication:**

☐

☐

**DOSAGE ORDERS:**

☐ Up to 55 kg 260 mg (2 vials)
☐ Greater than 55 kg to 85 kg 390 mg (3 vials)
☐ Greater than 85 kg 520 mg (4 vials)
☐ Other

**PREMEDICATION ORDERS:** *antihistamine and 100mg methylprednisolone are recommended in the PI* ☐ Acetaminophen po: ☐ 1000mg ☐ 500mg 30 min prior to infusion. ☐
Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion. ☐ Other

| | |
|---|---|
| Prescriber Name: Title: | |
| NPI: | DEA: |

| | |
|---|---|
| Prescriber Signature: Date of Order: | |

**Referrals will not be processed until we receive <u>ALL</u> the following:**

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ Lipids ☐ TB ☐ Hep B Other: