Conveniently Located in East Syracuse, Onondaga Hill & Auburn
Main Office Phone 315-472-7504
Nurse Navigator Phone 315-506-2469
Main Fax 315-634-5168

Methylprednisolone Non-Oncology Treatment Order Set

1. Patient Name: _____

2. DOB: _____ **Height (inches):** _____ **Weight (lbs):** _____

3. Diagnosis:

[ ] Primary ICD-10 Code: _____ Diagnosis description: _____
[ ] Other ICD-10 Code: _____ Diagnosis description: _____

HOACNY will obtain authorization for drug administration prior to scheduled infusion. If HOACNY is unable to obtain insurance authorization due to this medication not being in alignment with the insurance plan's medical policy, referring office will be notified and HOACNY will not be able to administer the medication.

4. Pre-medications:

[ ] Other Pre-medication: _____
[ ] No Pre-medications indicated

5. Drug Order:

Methylprednisolone IV *Ok to substitute with generic/biosimilar*
Dose:
[ ] 500 mg in 100 mL in NS over 1 hour
[ ] 1000 mg in 250 mL in NS over 1 hour
Frequency:
[ ] One time dose [ ] Daily x_____ dose(s)
[ ] Other: _____
[ ] Special Instructions: _____

HOA of CNY is responsible to provide nursing care, safe drug handling & administration, post-infusion observation & management of drug hypersensitivity reactions per the HOACNY Infusion Policy & Procedure Guidelines. Any changes in condition or delayed adverse events that occur after leaving the infusion center are to be reported to the prescribing physician for evaluation & management. The prescribing physician is responsible for educating the patient of potential risks & complications associated with drug administration as well as drug specific monitoring parameters before proceeding with Non-Oncology Infusion Referral

Physician's Name: _____ **Phone:** _____
Physician's Signature: _____**Date:** _____

(This drug administration order form is valid for 12 months)