

IV Solu-Medrol



InfusionForHealth.com

Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order.

Demographics and insurance. Relevant, recent office notes. Current medication list. H&P Relevant to the Diagnosis. Current CBC & CMP. TB Results.

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: G35 Multiple Sclerosis

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Center will use Hypersensitivity protocol established by Infusion for Health and P.I.

SOLU-MEDROL IV DOSAGE

Date of Last Treatment, If Continuation: _____

Administer: 500mg 1gram

Route: IV

Frequency:

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: List: _____

Prior to first appointment Other Frequency: _____

Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.