MIC | METRO INFUSION CENTER

# MEDICATION ORDERS- METHYLPREDNISOLONE

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Date of Referral: |

| REFERRAL STATUS |
|---|
| ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal |

| INFUSION OFFICE PREFERENCES (Optional) |
|---|
| Preferred Location*: |

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

| DIAGNOSIS AND ICD 10 CODE | |
|---|---|
| ☐ Multiple Sclerosis (MS) Exacerbation | ICD10 Code: G35 |
| ☐ Other: ________________________________________ | ICD 10 Code: __________________________ |

| REQUIRED DOCUMENTATION | |
|---|---|
| ☐ This signed order form by the provider | ☐ Clinical/Progress notes |
| ☐ Patient demographics AND insurance information | ☐ Labs and Tests supporting primary diagnosis |

| MEDICATION ORDERS | | | |
|---|---|---|---|
| Dosing | ☐ Methylprednisolone 1gm IV every day for a total of 5 doses<br>☐ Methylprednisolone 1gm IV ________________________________________<br>☐ Other: ____________________________________________________________ | | |
| Refills: | ☐ X 6 months | ☐ X 1 year | ☐ _____ doses |

| PRESCIBER INFORMATION | | |
|---|---|---|
| Prescriber Name: | | |
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | | Date: |

**Fax referral to (866) 507-1164 or email to MICreferral@metroinfusioncenter.com**

All information contained in this form is strictly confidential and will become part of the patient's medical record.

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