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 ☐ Methylprednisolone 1gm IV _____ ☐ Other: _____
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

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

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164