



RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Methylprednisolone IV

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION	
Date:	Patient Name: DOB:
☐ NKDA Allergies:	Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date:	Next Due Date:
PROVIDER INFORMATION	
Office Contact Name:	Office Email:
Prescribing Providers Name:	Provider NPI:
Office Address:	City: State: Zip:
Office Phone Number:	Office Fax Number:
DIAGNOSIS AND ICD 10 CODE	REQUIRED DOCUMENTATION
☐ Multiple Sclerosis (MS) Exacerbation ICD 10 Code: G35 ☐ Other: _____ ICD 10 Code: _____	☐ This signed order form by the provider ☐ Patient demographics AND insurance information (copy of cards) ☐ Clinical/Progress notes ☐ Lab and Tests supporting primary diagnosis
List Tried & Failed Therapies, including duration of treatment: 1. _____	
MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)	
Dosing	☐ Methylprednisolone 1gm IV every day for a total of 5 doses ☐ Methylprednisolone 1gm IV _____ ☐ Other: _____
Refills	☐ X6 months ☐ X1 year ☐ _____ doses
<i>*Please note: If an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion, or discontinuing the medication.</i>	

Provider Name (Print)

Provider Signature:

Date:

Fax Referral to 920-965-6389

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