



Patient Name: _____

Date of Birth: _____

PHYO
CMC85550-001NS Rev. 5/2021

**Methylprednisolone (SOLUMEDROL)
(SOTP) Infusion Therapy Plan**

Baseline Patient Demographic

To be completed by the ordering provider.

Diagnosis: _____ Height: _____ cm Weight: _____ kg Body Surface Area: _____ (m²)

NKDA - No Known Drug Allergies Allergies: _____

Therapy Plan orders extend over time (several visits) including recurring treatment.

Please specify the following regarding the entire course of therapy:

Duration of treatment: _____ weeks _____ months _____ unknown

Treatment should begin: as soon as possible (within a week) within the month

****Plans must be reviewed / re-ordered at least annually. ****

ORDERS TO BE COMPLETED FOR EACH THERAPY

ADMIT ORDERS

Height and weight

Vital signs

NURSING ORDERS

Please select all appropriate therapy

IV START NURSING ORDERS

Insert peripheral IV / Access IVAD

Place PIV if needed or access IVAD if available

lidocaine 1% BUFFERED (J-TIP LIDOCAINE)

0.2 mL, INTRADERMAL, PRN

when immediate procedure needed when procedure will take about 1 minute patient / family preference for procedure

Administration Instructions: NOTE: Do not use this medication in patients with bleeding disorders, platelets \leq 20,000, or in patients taking anticoagulants, when accessing implanted ports or using a vein that will be utilized for chemotherapy administration, nor for pre-term infants or neonates.

lidocaine - prilocaine (EMLA) cream

TOPICAL, PRN

when more than 60 minutes are available before procedure when procedure will take more than 1 hour

patient / family preference for procedure

Administration Instructions: NOTE: In children < 3 months of age, or < 5 kg in weight, maximum application time is 1 hour.

lidocaine - tetracaine (SYNERA) patch

TOPICAL, PRN

when 20 - 30 minutes are available before procedure when procedure will take more than 1 hour

when anticipated pain is less than 5 mm from skin surface patient / family preference for procedure

lidocaine with transparent dressing 4% kit

TOPICAL, PRN

when 20 - 30 minutes are available before procedure when procedure will take more than 1 hour

patient / family preference for procedure



Patient Name: _____

Date of Birth: _____

PHYO
CMC85550-001NS Rev. 5/2021

**Methylprednisolone (SOLUMEDROL)
(SOTP) Infusion Therapy Plan**

ORDERS TO BE COMPLETED FOR EACH THERAPY

NURSING ORDERS, CONTINUED

Please select all appropriate therapy

Heparin flush

heparin flush

10 - 50 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. This heparin flush should be used with all central lines including IVADs, with the exception of de-accessing the IVAD.

heparin flush

100 - 300 units, INTRAVENOUS, PRN, IV line flush. Per protocol, heparin should not be used to flush peripheral IVs. For use only when de-accessing IVADs.

Sodium chloride flush

Sodium chloride flush 0.9% injection

1 - 20 mL, INTRAVENOUS, PRN, IV line flush

Sodium chloride - preservative free 0.9% injection

1 - 30 mL, INTRAVENOUS, PRN, IV line flush

PRE - PROCEDURE LABS

<input checked="" type="checkbox"/> Complete Blood Count with Differential Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input checked="" type="checkbox"/> Renal Function Panel Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input checked="" type="checkbox"/> Hepatic Function Panel Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input checked="" type="checkbox"/> Gamma Glutamyl Transferase Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input checked="" type="checkbox"/> Magnesium Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input checked="" type="checkbox"/> Phosphorus Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input checked="" type="checkbox"/> Reticulocytes Unit collect	INTERVAL: Every visit	DURATION: For 5 treatments
<input type="checkbox"/> Tacrolimus Unit collect, to be drawn PRIOR to morning dose	INTERVAL: Once DEFER UNTIL: _____	DURATION: For 1 treatment
<input type="checkbox"/> Cyclosporine Random Unit collect, to be drawn PRIOR to morning dose	INTERVAL: Once DEFER UNTIL: _____	DURATION: For 1 treatment
<input type="checkbox"/> Sirolimus Unit collect, to be drawn PRIOR to morning dose	INTERVAL: Once DEFER UNTIL: _____	DURATION: For 1 treatment

INTRA-PROCEDURE

- Measure Blood Pressure**
Monitor blood pressure every 15 minutes during methylprednisolone infusion. Hold infusion for blood pressure \geq _____ and contact ordering provider.
- Physician Communication Order**
Dosing of methylprednisolone below. Please enter the dose of methylprednisolone in 'mg' to facilitate authorization requirements: 10 mg / kg to 20 mg / kg (maximum of 1,000 mg) IV daily x 3 to 5 days (treatments).

Key: BP = blood pressure; cm = centimeter; IV= intravenous; IVAD = implantable venous access device; kg = kilogram; m²= square meters; mg = milligram; mL= milliliter; mL / hr = milliliters per hour; mOsm / L = milliosmole per liter; NKDA = no known drug allergies; pH = hydrogen ion concentration; PIV = peripheral intravenous; PRN = as needed; RTA = ready to administer; SBP = systolic blood pressure; SOTP = Solid Organ Transplant



Patient Name: _____

Date of Birth: _____

PHYO
CMC85550-001NS Rev. 5/2021

**Methylprednisolone (SOLUMEDROL)
(SOTP) Infusion Therapy Plan**

ORDERS TO BE COMPLETED FOR EACH THERAPY

INTRA-PROCEDURE, CONTINUED

methylPREDNISolone RTA infusion **INTERVAL: Every 1 Day** **DURATION: For 3 Treatments**

For doses \geq to 10 mg / kg, see Policy 7.10.16 assess and document heart rate and blood pressure every 15 minutes during infusion and for 1 hour after the infusion is complete. Doses > 15 mg / kg should be given over a minimum of 1 hour. Administer over 90 minutes.

Dose: _____

methylPREDNISolone RTA infusion **INTERVAL: Every 1 Day** **DURATION: For 4 Treatments**

For doses \geq to 10 mg / kg, see Policy 7.10.16 assess and document heart rate and blood pressure every 15 minutes during infusion and for 1 hour after the infusion is complete. Doses > 15 mg / kg should be given over a minimum of 1 hour. Administer over 90 minutes.

Dose: _____

methylPREDNISolone RTA infusion **INTERVAL: Every 1 Day** **DURATION: For 5 Treatments**

For doses \geq to 10 mg / kg, see Policy 7.10.16 assess and document heart rate and blood pressure every 15 minutes during infusion and for 1 hour after the infusion is complete. Doses > 15 mg / kg should be given over a minimum of 1 hour. Administer over 90 minutes.

Dose: _____

Therapy Appointment Request

Please select department for the therapy appointment request:

Expires in 365 days

Dallas Special Procedures Plano Infusion Center Dallas Allergy Dallas Transplant Dallas Neurology

EMERGENCY MEDICATIONS

Nursing communication

1. Hives or cutaneous reaction only – no other system involvement

PATIENT IS HAVING A DRUG REACTION:

- a. Stop the infusion
- b. Give diphenhydramine as ordered
- c. Check heart rate, respiratory rate and blood pressure every 5 minutes until further orders from provider.
- d. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation) if not already on one
- e. Notify provider for further orders

2. Hives or cutaneous reaction plus one other system, i.e. abdominal cramping, vomiting, hypotension, altered mental status, respiratory distress, mouth / tongue swelling

PATIENT IS HAVING ANAPHYLAXIS:

- a. Stop the infusion
- b. Call code – do not wait to give epinephrine
- c. Give epinephrine as ordered
- d. Notify provider
- e. Check heart rate, respiratory rate and blood pressure every 5 minutes until the code team arrives.
- f. Connect patient to monitor (cardiac / apnea, blood pressure and oxygen saturation), if not already on one.
- g. Give diphenhydramine once as needed for hives
- h. May repeat epinephrine every 5 minutes x 2 doses for persistent hypotension and respiratory distress with desaturation until code team arrives.
- i. May give albuterol as ordered for wheezing with oxygen saturation stable while waiting for code team, continue to monitor oxygen saturation.

Hypotension is Defined as Follows:

1 month to 1 year – systolic blood pressure (SBP) less than 70
 1 year to 11 years – systolic blood pressure (SBP) less than 70 + (2 x age in years)
 11 years to 17 years – systolic blood pressure (SBP) less than 90
 OR any age – systolic blood pressure (SBP) drop more than 30% from baseline.
 Baseline systolic blood pressure (SBP) x 0.7 = value below defined as hypotension.



Patient Name: _____

Date of Birth: _____

PHYO
CMC85550-001NS Rev. 5/2021

**Methylprednisolone (SOLUMEDROL)
(SOTP) Infusion Therapy Plan**

ORDERS TO BE COMPLETED FOR EACH THERAPY

EMERGENCY MEDICATIONS, CONTINUED

- EPINEPHrine Injection Orderable For Therapy Plan
(AMPULE / EPI - PEN JR. / EPI - PEN) 0.01 mg / kg**

0.01 mg / kg, INTRAMUSCULAR, EVERY 5 MINUTES PRN, for anaphylaxis and may be repeated for persistent hypotension and respiratory distress with desaturation until the code team arrives, for 3 doses

Use caution with PIV administration. This solution has a pH < 5, or a pH > 9, or an osmolality > 600 mOsm / L.

Dose: _____

- Cardio / Respiratory Monitoring
Rationale for Monitoring: High risk patient (please specify risk)**

- Clinically significant cardiac anomalies or dysrhythmias
- Recent acute life-threatening event
- Unexplained or acutely abnormal vital signs
- Artificial airway (stent, tracheostomy, oral airway)
- Acute, fluctuating or consistent oxygen requirements

Monitor Parameters (select all that apply): Heart rate Oxygen saturation Respiratory rate

Telemetry Required: Yes No

- diphenhydrAMINE injection**

1 mg / kg, INTRAVENOUS, ONCE PRN, for hives or cutaneous reaction, for 1 dose maximum dose = 50 mg per dose, 300 mg per day.

Dose: _____

- Albuterol for aerosol**

0.25 mg / kg., INHALATION ONCE PRN, for wheezing, but oxygen saturations stable while waiting for code team, continue to monitor oxygen saturation for 1 dose

Dose: _____

POST-PROCEDURE

- Nursing communication**

Flush PIV or IVAD with 20 mL 0.9% sodium chloride (250 mL bag) at the completion of the infusion.
Flush IVAD with saline and heparin flush per protocol prior to de-accessing IVAD.
Discontinue PIV prior to discharge.

- Sodium chloride 0.9% infusion**

INTRAVENOUS, at 0 - 25 mL / hour ONCE, for 1 dose

Dose: _____

(circle one):
MD DO

Signature of Provider

Credentials

Date

Time

Printed Name of Provider