



Riverbend Medical Center Regional Infusion Center (RIC)
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Methylprednisolone (Solu-Medrol) Order Set (v. 09/04/2025)

Diagnosis/Indication (ICD-10): _____

Medications:

- .. Methylprednisolone 1 gram IVPB daily over 1 hour x _____ days
- .. Methylprednisolone _____ mg IVPB over 1 hour daily x _____ days

Nursing communications:

- Vital signs: Initial and as needed during infusion

Access:

- .. Insert peripheral IV
 - Okay to leave peripheral IV in for duration of daily therapy. Flush with normal saline before and after use. Remove after IV daily treatment complete.
- .. Access & Use Central Line/ CVAD
 - Initiate Central Line (Non-PICC) Maintenance Protocol
 - Heparin, porcine (PF) 100 unit/mL flush 5 mL as needed for Port-a-Cath line care
 - Alteplase (Cathflo) 2 mg as needed for occluded catheter. For clearing central line catheter- retain in catheter for 30 minutes to 2 hours, instill a 2nd dose if occluded
- .. Access & Use PICC
 - Initiate PICC Maintenance Protocol
 - Normal saline flush 3 mL as needed for PICC/ Hickman line care
 - Alteplase (Cathflo) 2 mg as needed for occluded catheter. For clearing central line catheter- retain in catheter for 30 minutes to 2 hours, instill a 2nd dose if occluded

Emergency Medications: (May give emergency medications IM if IV route unavailable)

- Diphenhydramine (BENADRYL) 25 to 50 mg IV as needed for mild to moderate drug reactions (flushing, dizziness, headaches, diaphoresis, fever, palpitations, chest discomfort, blood pressure changes (≥ 20 points in SBP), nausea, urticaria, chills, pruritic). Administer 25 mg IV once, if reaction does not resolve in 3 minutes may repeat 25 mg IV dose for a total of 50 mg and contact provider.
- Epinephrine 0.3 mg IM once for anaphylaxis. If reaction does not resolve in 3 minutes may repeat 0.3 mg IM dose for a total of 0.6 mg. Avoid use of hand, foot, leg veins in elderly patient and those with occlusive vascular disease. Contact provider if given.
- Famotidine (PEPCID) 20 mg IV once as needed for infusion/ allergic reaction.

Patient name: _____

DOB: _____

Height _____ Weight _____

Provider printed name: _____

Provider signature: _____

Date: _____ Time: _____