INTRAMED Plus
infusion services

INJECTAFER®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Iron Deficiency Anemia ICD-10 Code: D50.9 _____
_____ Iron Deficiency Anemia secondary to blood loss (chronic) ICD-10 Code: D50.0 _____
_____ Anemia complicating pregnancy ICD-10 Code: 099.019 _____
_____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - Recent lab results including a hemoglobin, hematocrit and iron studies
- Infusion Center – Lab Orders: _____

Patient
Weight: _____ lbs.
Height: _____ in.

INJECTAFER® (ferric carboxymaltose) J Code: J1439

4. Drug Order:

❑ For patients less than 50 kg , Injectafer 15mg/kg/dose for two doses to be given at least 7 days apart.

❑ For patients > 50kg, Injectafer 750mg for two doses to be given at least seven days apart.

Maximum total dose: 1500mg

_____ Cycles Authorized – Each cycle includes two doses not to exceed 1,500 mg combined

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	**COLUMBIA CHARLESTON GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**

NOV 2019