

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: D099.019
 _____ 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.

MONOFERRIC® (ferric derisomaltose) J Code: J1437

4. Drug Order:

For patients less than 50 kg (110 lbs), administer one dose of Monoferric 20 mg/kg (_____ mg) IV

For patients greater than 50 kg (110 lbs), administer one dose of Monoferric 1000 mg IV

***** Intramed Plus may contact you to discuss other iron formulations based on patient's insurance coverage*****

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved 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 CENTRAL FAX 803.999.1754	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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