INTRAMED Plus
infusion services

MONOFERRIC®

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

Patient
Weight: _____ lbs.
Height:_____ in.

- Infusion Center — Lab Orders: _____

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 greather 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	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 803.999.1960