

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: _____ Urinary tract infection ICD-10 Code: N39.0 _____
 _____ 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
 - Disease history including previous treatments and outcomes
 - Culture & Sensitivity Test Results
- Baseline laboratory results include serum creatinine

Patient Weight: _____ lbs. Height: _____ in.

ZEMDRI® (plazomicin) J Code: J3490

4. Drug Order:

Administer Zemdri _____ mg (15mg/kg) every 24 hours IV over 30 minutes for _____ doses
 (Creatinine clearance >60 – 90mL/min)

For patients with impaired renal function

- Administer Zemdri _____ mg (10 mg/kg) every 24 hours IV over 30 minutes for _____ doses
 (Creatinine clearance >30 – 59mL/min)
- Administer Zemdri _____ mg (10 mg/kg) every 48 hours IV over 30 minutes for _____ doses
 (Creatinine clearance >15 – 29mL /min)

Pre-Medication Orders: _____
 No pre-medications are recommended based on manufacturer guidelines.

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