

**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: O99.019  
\_\_\_\_\_ Other: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
Allergies: \_\_\_\_\_ (or attach list)

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

- Clinical notes, labs, test supporting primary diagnosis
  - Recent lab results including a hemoglobin, hematocrit and iron studies
- Infusion Center — Lab Orders: \_\_\_\_\_

<b>Patient</b>
<b>Weight:</b> _____ lbs.
<b>Height:</b> _____ in.

**FERAHEME® (ferumoxytol injection)**

J Code: Q0138

**4. Drug Order:**

- Administer 510 mg Feraheme IV followed by a second 510 mg Feraheme dose 3-8 days after the initial dose
- Other: \_\_\_\_\_

**\*\*\* 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.

**Pre-Medication Orders:** \_\_\_\_\_  
No Pre-medications are recommended based on manufacturer guidelines.

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 #: \_\_\_\_\_

<p><b>FAX ALL INFORMATION</b> <b>CENTRAL FAX 803.999.1754</b></p>	<p><b>INFUSION CENTER LOCATIONS</b> <b>BERKELEY CHARLESTON COLUMBIA GREENVILLE</b> <b>CENTRAL INTAKE PHONE 803.999.1760</b></p>
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