INTRAMED Plus
infusion services

VENOFER®

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 in chronic kidney disease — ICD-10 Code: D63.1
_____ 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
- Medication List
- Infusion Center–Lab Orders (Check order for Infusion Center to manage):

❑ _____

Patient
Weight: _____ lbs.
Height: _____ in.

VENOFER® (iron sucrose) J Code: J1756

4. Drug Order:

❑ Administer 200 mg IV on 5 different occasions within 14-day period
Doses Authorized: 5 (total cumulative dose: 1000 mg)

❑ Administer 300 mg IV on day 1 and again day 14, followed by a single 400 mg infusion day 28.
Doses Authorized: 3 (total cumulative dose: 1000 mg)

❑ Other: _____

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 with Credentials: _____ NPI: _____

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

JUNE 2023