INTRAMED Plus
infusion services

ZEMDRI®

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**	**INFUSION CENTER LOCATIONS** **BERKELEY CHARLESTON COLUMBIA GREENVILLE** **CENTRAL INTAKE PHONE 803.999.1760**